Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Maryland** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Living at Home Waiver Program

C. Waiver Number: MD.0353
Original Base Waiver Number: MD.0353.

D. Amendment Number: MD.0353.R02.01

E. Proposed Effective Date: *(mm/dd/yy)*

11/01/09

Approved Effective Date: 11/01/09
Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purposes of the amendment are to:

1. Add transitional and on-going case management as waiver services using the provisions established under a concurrent 1915 (b)(4)waiver.
2. Revise cost neutrality calculations and cost estimates as a result of adding case management as a service.
3. Change timeframes for reporting and/or completing the reportable event process involving specified events (incidents/complaints) that must be reported based on the Department's Reportable Event policy.
4. Increase individual cost limit from 115% to 125% of the institutional average.
5. Add and modify performance measures.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)

☑ **Waiver Application**	1-7
☑ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	2-a and 2-
☑ **Appendix C – Participant Services**	1,2 and 4
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☑ **Appendix E – Participant Direction of Services**	1-j
☐ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	1 and 2
☐ **Appendix H**	
☑ **Appendix I – Financial Accountability**	1 and 2
☑ **Appendix J – Cost-Neutrality Demonstration**	1 and 2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

  Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Living at Home Waiver Program

C. Type of Request: amendment

Original Base Waiver Number: MD.0353
Waiver Number: MD.0353.R02.01
Draft ID: MD.09.02.01

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/09
Approved Effective Date of Waiver being Amended: 07/01/09

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Not applicable

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

A 1915(b)(4) waiver application was submitted to CMS and approved with an effective date of November 1, 2009.

Maryland's request for a new section 1915(b)(4) waiver, entitled Living at Home Waiver for Case Management has been assigned control number MD01.000.01 for the period 11/1/2009 to 10/31/10 and MD01.000.02 for the period starting 11/1/2010 to 9/30/2011.

Transitional and on-going case management are provided by an entity identified through a competitive solicitation process and operates in conjunction with the provisions established under a 1915(b)(4) waiver approved on 11/1/2009.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Living at Home Waiver(LAH) program is designed to provide cost-effective Home and Community-Based Medicaid Waiver Services to adults with physical disabilities who are enrolled between the ages of 18 and 64 years. LAH services are offered to participants as an alternative to institutional care in a nursing facility. The goals of the waiver are to provide quality services for individuals in the community, ensure the well-being and safety of the participants and to increase opportunities for self-advocacy and self-reliance.

Objectives for this waiver renewal include enhancing service delivery through improving outcome-based quality assurance systems and to improve the quality of nurse monitor services.

The organizational structure:
The Department of Health and Mental Hygiene (DHMH), Office of Health Services (OHS) has full administrative authority over the LAH Waiver Program, located within the Living at Home Waiver Division. LAH is supervised by a Division Chief who reports to the Deputy Director for Long Term Care and Waiver Services in the OHS. The LAH Waiver Division is responsible for daily waiver operations and administration of the program. Historically, LAH has been responsible for procuring, maintaining and monitoring contracts for two administrative services available to waiver participants. Fiscal intermediary services (FI) and case management contractors are selected through a competitive bid process and are available statewide. On October 31, 2009, the contract for case management services ended; LAH moved from the administrative case management model to providing administrative, transitional and on-going case management as billable waiver services available to eligible applicants and participants effective November 1, 2009.

Fiscal intermediaries act as the payroll agent for participants electing the non-agency (consumer) model of attendant care. In this role, they ensure employee documentation verification, pay quarterly taxes, obtain appropriate insurance policies for Workers' Compensation, issue W-2 forms, review time sheets for accuracy and make regular payroll payments. LAH regularly reviews claims payment and reporting information from the FI.

Case management services are provided to assist applicants and participants with their initial annual eligibility determination process. Case managers provide applicants with assistance in locating housing, informal supports and waiver services; the delivery of these services is critical to applicants' ability to transition to the community from nursing facilities. Case Managers serve as agents of the Department that are responsible for assisting participants with eligibility determination, accessing all waiver, non-waiver services, benefits and entitlements needed to maintain healthy and safe community living. Program participants and/or their representative(s) are actively involved in working with case managers in order to make informed decisions about waiver services and providers. LAH reviews case management invoices and monitors case management service delivery to waiver participants.

Eligibility
Applicants must meet a nursing level of care (LOC) in order to meet medical criteria for program eligibility. The initial and annual LOC determination is made by the Department's contracted Utilization Control Agent after receiving evaluation information and other requested documents. The UCA Contract Monitor conducts regular reviews to ensure that LOC determinations are completed according to regulatory requirements. In order to participate in the waiver program, applicants must also meet technical (age) and financial eligibility.

Participants are offered an array of waiver, State Plan Medicaid and community supports and services. Each participant is able to choose between consumer-directed or agency based attendant care services; in addition the participant and/or their representative reviews, signs and receives a copy of their plan of service. Case managers actively engage participants for on-going decision-making about model of attendant care, provider choice, provider schedule, and other service delivery options. Case Managers are responsible for documenting information in a web-based tracking system as well as reporting critical events, incidents and complaints through the Department’s “Reportable Events” Policy and Procedure. They are also responsible for monitoring cost neutrality for each participant.

The LAH Waiver Division staff approves services plans and monitors cost neutrality. Division staff maintains a reportable events/complaints data-base. LAH staff analyzes reportable event/complaint data and generates reports. The reports are shared with and evaluated by the Quality Waiver Council which is comprised of representatives from all of the 9 home and community-based services waivers and other agency representatives.

Providers must meet waiver conditions of participation based on provision of services and are required to submit an application with other requested documentation to LAH staff. Staff members are responsible for certification and enrollment of providers as well as on-going review of provider credentials and requirements. Many providers must also meet licensing requirements mandated by the State's Office of Health Care Quality. The 1915 (b) waiver allows the Department to limit providers of case management services.

The DHMH, OHS, Division of Evaluation and Quality Care Review (QCR) have a team of professionals including registered nurses and social workers who conduct annual on-site visits, observations, and interviews and record reviews of a random sample of LAH participants. These reviews are conducted to ensure the health, welfare, and safety of waiver participants. The QCR Team evaluates program services/satisfaction and/or identifies issues which may require a plan of correction by the providers and a procedural or system change.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

No

Yes

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the

provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Living at Home Waiver Program has established an advisory committee that meets five times per year. This group is comprised of waiver participants and providers, community advocates, contractual representatives and Office of Health Services staff. This group discusses waiver activities and areas where modifications are requested.

In addition, public input about the waiver has been obtained through the Money Follows the Person (MFP) demonstration grant stakeholder group. The MFP project also held smaller work groups to address areas where changes to the waiver were recommended. One area of interest was improving waiver participant's ability to access behavioral health supports in the community. This area will be further explored during the first year of the LAH waiver renewal and recommendations will be included in the first annual report.

In preparation for the waiver renewal, LAH staff sent a mailing to all waiver participants and/or their designee in an attempt to solicit feedback. Participants and/or their designee were offered a choice between providing feedback through a regional focus group, an individual in-home meeting, an online survey tool, a telephone survey or a survey to be completed via mail. The case manager assigned to each participant then followed up to determine if individuals were interested in providing feedback and their preferred method of doing this. Approximately forty-five percent of the program participants or their designated representatives did not respond or responded that they are not interested in providing input at this time; approximately fifty-five percent of those who responded expressed interest in participation.

The greater Baltimore region was affirmative about participating in a focus group and two participants were sought to co-facilitate the meeting. However, after calculating the number of potential respondents, LAH realized neither the survey nor the group size were consistent with a statistically significant sample size. A few individuals within the advisory group expressed concerns about the new application assistance process. LAH did not move forward with this process. At present, the LAH Advisory Group has elected a waiver participant to facilitate all future meetings. LAH has increased the number of advisory meetings annually and worked to increase recipient participation in these groups.

Additionally, a few individuals within the advisory group have expressed concerns about the new application assistance process. LAH has agreed to monitor the new process which was implemented November 2009, and provide feedback to the advisory group. LAH will be working with the advisory group on quality initiatives as well.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance

Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Brownell
First Name:	Sandra
Title:	Deputy Director of Long Term Care and Waiver Services
Agency:	Maryland Department of Health and Mental Hygiene, Office of Health Services
Address:	201 W. Preston Street Room 122
Address 2:	
City:	Baltimore
State:	**Maryland**
Zip:	21201
Phone:	(410) 767-5234 **Ext:** ☐ **TTY**
Fax:	(410) 333-6547
E-mail:	brownells@dhmh.state.md.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	
First Name:	
Title:	
Agency:	
Address:	
Address 2:	
City:	
State:	**Maryland**
Zip:	
Phone:	**Ext:** ☐ **TTY**
Fax:	
E-mail:	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements

specified in Section 6 of the request.

Signature:	Jane Wessely
	State Medicaid Director or Designee
Submission Date:	Apr 22, 2010

Last Name:	Folkemer
First Name:	John
Title:	Deputy Secretary for Health Care Financing
Agency:	Department of Health and Mental Hygiene
Address:	201 West Preston Street
Address 2:	
City:	Baltimore
State:	**Maryland**
Zip:	21201
Phone:	(410) 767-4139
Fax:	(410) 333-7687
E-mail:	folkemerj@dhmh.state.md.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - (●) **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - (●) **The Medical Assistance Unit.**

       Specify the unit name:
       Living at Home Waiver Division
       (Do not complete item A-2)

     - ( ) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   - **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   - **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Adult Evaluation and Review Services
The Adult Evaluation and Review Services or AERS refers to a program operated by local health departments (LHDs) of Maryland's 24 political subdivisions. The Office of Health Services has a Memorandum of Understanding with the local departments for the purpose of providing payment for comprehensive long term care evaluations. The AERS staff includes registered nurses, licensed social workers, and other members of a multi-disciplinary team who conducts comprehensive evaluations which addresses the following areas: medical/nursing, functional, psycho-social and environmental assessments for individuals at risk of institutionalization. The team assists the individual, family, personal physicians and others by developing an appropriate plan of care to help the individual remain in the least restrictive environment. After developing a recommended plan of care, AERS provides a copy of their recommendations to the contracted case management agency. Generally, the AERS staff conduct the initial and annual comprehensive evaluations for applicants and participants. AERS does not provide treatment.

The Hilltop Institute
The Hilltop Institute, formerly the Center for Health Programs and Data Management, located at the University of Maryland Baltimore County has a Memorandum of Understanding with the Department of Health and Mental Hygiene. Under this MOU, the Hilltop Institute collects, analyzes and reports on program information/data. The Hilltop Institute is responsible for developing and maintaining the LAH tracking system. In addition, this agency is responsible for backing up program data and ensuring secure storage for all program information. The Hilltop Institute developed and maintains the Quality Care Review Team web-based tracking system which can access pertinent data from the LAH tracking system. The QCRT tracking system collects and analyzes LAH waiver review data and generates findings reports.

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Case Management
Under the approved 1915(b)(4), case management services are contracted and a payment rate is established in regulations. The contracted case management agency assists applicants and participants with the initial and annual eligibility
determination process as well as coordinate services required for healthy and safe community living. The contracted case
management agency is required to submit monthly and quarterly reports about critical incidents and events. This agency is responsible for analyzing service utilization based on claims data provided by the LAH Waiver Division. Case managers are required to administer transition services for participants enrolling in the waiver from nursing facilities.
Beginning in 2008, the LAH waiver implemented the a web-based application and tracking system which case
managers use to track the eligibility process and access information. Several reports are being built into the tracking system which will allow the LAH staff to have real time access to information about eligibility determination and case status.

Fiscal Intermediary Services Contract
Fiscal intermediary services are provided to waiver participants using the non-agency or consumer model of attendant care services. The fiscal intermediary acts as the payroll agent on behalf of these participants;

in this capacity, the fiscal intermediary is responsible for issuing bi-weekly provider payroll checks, collecting and paying federal and state tax withholding and unemployment insurance, as well as securing and maintaining workers' compensation insurance policies. The fiscal intermediary assists new participant employers in obtaining an Employment Identification Number from the Internal Revenue Service. The fiscal intermediary collects mandatory employee documentation including the social security number, documents to support the I-9 form, and the IRS W-4 form. The fiscal intermediary invoices LAH an administrative fee for their services and is reimbursed for the Medicaid provider wages, taxes and workers'

compensation. The contract is monitored by the Agency Budget Specialist in the Living at Home Waiver Division.

Utilization Control Agent
The Office of Health Services in the Department of Health and Mental Hygiene contracts with a Utilization Control
Agent (UCA) which is responsible for determining medical eligibility for programs that require a nursing facility level of care. The UCA is responsible for making medical level of care determinations for initial and annual evaluations for the Living at Home Waiver Program.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Office of Health Services in the Department of Health and Mental Hygiene monitors the performance of all contracts.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Office of Health Services in the Department of Health and Mental Hygiene monitors the performance of the following contracts:

Utilization Control Agent
The Utilization Control Agent Contract is managed under the Division of Long Term Care Services and monitored by the Chief of the Division of Long Term Care Services. The UCA contract (SMA) monitor reviews monthly invoices, aggregated data, and individual program reports to determine timeliness and identify outliers. The contract monitor ensures that quarterly reports are completed to verify the accuracy and appropriateness of the LOC determinations. Registered Nurses and physicians working in the Division of Long Term Care Services (SMA) review all pending appeal cases to evaluate the timeliness, accuracy and appropriateness of the LOC denial; reversals are initiated where appropriate. This information is compiled into a UCA LOC report and analyzed. Actions are taken based on the analyzed data.

Fiscal Intermediary Services
The Fiscal Intermediary Contract is monitored by the Agency Budget Specialist in the LAH waiver. The Fiscal Intermediary contract requires the vendor to submit deliverables monthly and quarterly. In addition, staff monitor all claims paid by this contract through a continuous and ongoing internal process. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

Case Management Agency
The contracted case management agency continues to be monitored by staff in the Living at Home Waiver Division. The case management contract is monitored by the Medical Care Program Specialist in the Living at Home Waiver Division. The case management agency is required to submit billing documents/invoices, summary activity reports, reports of complaints, incidents and critical events. This entity submits quarterly reports on participant service utilization and quality measures including monitoring activities. In addition, this contractor is required to perform monthly contacts, and quarterly face-to-face visits with program applicants and participants.

LAH staff perform site visits to monitor the agency's record keeping and adherence to program policies and procedures. Reporting of these findings is compiled on a quarterly basis. The LAH Waiver Division implemented the use of a participant tracking system in 2008; future monitoring of routine activities and time frames for eligibility determination completion will be completed through reports that are built into the tracking system.

The case management contractor must meet with the LAH Waiver Division monthly for the purpose of ongoing communication and technical assistance. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☐
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be

specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Completion of an annual report beginning in March, 2010. LAH will compile an annual HCBS Waiver Review Report including statistics on enrollment,demographics, annual cost, service utilization, distribution of costs for waiver and State Plan Medicaid services, performance on quality measures, remediation initiatives, system design improvements, stakeholder recommendations and overall trends.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from the LAH Tracking System and Case Management, LAH Advisory, Money Follows the Person Stakeholders(through 2011) and Annual Participant Focus Group meetings. The annual QCR Team report.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CM and FI Contractors QCR Team	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☑ **Other** Specify: Hilltop Institute	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of providers who receive training. LAH will provide training sessions for Nurse Monitor & Attendant Care providers in FY 2010. LAH will require at least annual training for these providers based on regulation changes by 2011. Numerator: Number of provider agencies who receive training. Denominator: Number of Provider Agencies currently working with LAH participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Service Reports, Reportable Events,Participant Feedback, Case Manager Documentation

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentages of Plans of Service (POS) approved prior to accessing services. Numerator: Number of POS approved in advance of service delivery. Denominator: Total number of POS completed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Record reviews completed in the LAH Tracking System.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of Plans of Service within required limits. Numerator: Total number of POS above 125% of cost neutrality. Denominator: Total number of approved POS for enrolled participants.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
LAH tracking system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of applicants and participants who are evaluated for Level of Care initially & annually. Numerator: Total number of LAH Level of Care determinations completed initially & annually. Denominator: Total number of waiver applicants and participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
LAH Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

	Specify:

Performance Measure:
Percentage of participants who receive 100% of services specified in their waiver plan of service (POS) annually. Numerator: Number of LAH participants receiving 100% of waiver services based on their POS annually. Denominator: Number of LAH waiver participants receiving services annually.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Electronic Billing System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of applications with eligibility determinations completed within 30 days of the date of the application. Numerator: Number of LAH initial eligibility determinations completed within 30 days of the date of the application. Denominator: Number of LAH applications completed annually.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
LAH Tracking System report will provide information on a monthly basis beginning in April 2009

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Reportable Events(RE)including complaints are submitted to LAH based on established procedures from providers, case managers, consumers, etc. The LAH Quality Assurance (QA) Specialist reviews all REs and complaints, determines if additional information is needed or if other actions are required including referrals and/or on-site visits. They are submitted daily and entered into a reportable events database tracking system.

Email
Calls
Letters
Faxes
Referrals

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The SMA functions as the administering agency through the Living at Home Waiver Division as well as the authority. The FI contracted entity is monitored directly by LAH Agency Budget Specialist & Medical Care Program Associates. All claims are reviewed and verified against timesheets and POS. When there are discrepancies, claims are sent back to providers and must be corrected. Claims are all put into an LAH electronic billing system and then transmitted to the MMIS for payment. The MMIS system will not pay claims that do not meet edit criteria for the specific service. Reports are generated and data is analyzed to identify any problems or trends. Medicaid fraud issues are referred to the Division of Waiver Programs Compliance Unit and as necessary to the Medicaid Control Fraud Unit for investigation and possible recoveries. The LAH Health Policy Analyst Associate (HPA), Medical Care Program Specialist Supervisor & Division Chief all play a role in reviewing information in the LAH tracking system. The HPA approves POS routinely and checks to see that case management is performing initial POS & annual POS timely. When issues are identified the case manager is notified of the problem immediately. Further actions are taken if the problem is not resolved which can include technical assistance, training, one to one sessions. Other remedies may be imposed. The QCRT does an annual review of a sample of LAH participants in the LAH program. The team reviews the clinical record,, does on-site observations and interviews to ensure participants received services per the plan of care and that their needs are being met. When case management issues or other provider issues are identified during the review, a Corrective and Preventative Action Plan (CAPA)is required of the providers. Responses are requested based on established timelines. If the responses are rejected, the provider including the case management agency must respond within 10 days with an acceptable plan. In addition, the team reviews the AERS recommendations and assessments. When problems are identified they are addressed the same way. There is a also Nurse Consultant with the Division of Evaluation & Quality Review (SMA) that works closely with the local health department AERS staff to ensure compliance with the requirements. There are quarterly regional meetings, either on-site or through teleconferences to address changes and discuss concerns. The UCA is monitored by the Division Chief for Long Term Care Services. The contracted unit submits monthly and quarterly reports which are reviewed by the Division Chief and distributed to the waiver programs. Identified problems are addressed immediately with the agency. At least quarterly conference calls are conducted with the UCA to review any issues or changes in activities including policy changes or requirements.
Individual participant and provider problems including the contracted FI and case management agency are identified through reportable events, complaints, case notes, provider service reports, provider claims and other sources. These are all tracked through the LAH RE tracking system. Reports are generated to review & analyze the data. Changes maybe made based on the analysis of the data. Problems/events are triaged by LAH Waiver Division or by other Long Term Care & Waiver staff (SMA)to determine response time and what action is necessary based on an evaluation of the information submitted and requested and as specified in the current reportable events policy & procedures.

The Waiver Quality Council meets quarterly and all waiver programs are required to submit quarterly reportable events data and to share any changes in program design or problems/issues. The Council reviews the data and makes recommendations and policy changes based on an analysis of the information and on additional research/study information. The LAH program makes referrals to other agencies/boards who may also have jurisdiction for a provider, individual, etc. The SMA oversees and remediates issues for contracted entities,providers, participants, AERS, UCA, etc.through various methods including but not limited to tracking systems, reportable events/complaints, on-site reviews, off-site,interviews, observations, Waiver

Quality Council activities and other stakeholder activities.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☑	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
○ **Mental Retardation or Developmental Disability, or Both**					

	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Individuals must meet nursing facility level of care standard in Maryland, have a waiver plan of service that includes all waiver and state plan services. Individuals must have a waiver plan of service that is within the State cost neutrality guidelines and includes all services necessary to meet the health, welfare and safety needs of the individual in a community setting. All participants must choose to receive services in the community versus a nursing facility or other location.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

If enrolled by age 64, Living at Home Waiver participants may remain in the program throughout their life span as long as they continue to meet eligibility requirements. Additionally, all applicants who are approaching the age limit of 64 are informed about Maryland's Home and Community-Based Services Waiver for Older Adults as well as other regional resources that may be accessed through the Area Agencies on Aging or Commission on Aging.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

◉ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

◉ **A level higher than 100% of the institutional average.**

Specify the percentage: 125

○ **Other**

Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

  - **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Each LAH applicant is assessed by the Adult Evaluation and Review Services staff, located in the local health departments throughout the State. This entity completes a medical and social evaluation of the applicant, including a complete record review,and makes recommendations about the type, frequency and duration of any services necessary to ensure healthy and safe community living. The recommendations are forwarded to the case manager assigned to work with the applicant. The case manager reviews the AERS recommended plan of care and other

documents with the applicant; together they develop a plan of services including all services to live safely in the community. The case manager's plan of services may differ from the recommendations made by AERS in that the applicant may choose some informal care, or a different service to meet a specific need.

After the plan of services is completed by the case manager, it is forwarded to the Living at Home Waiver Division for approval. Each plan is reviewed to ensure that it includes all necessary services or another indication of how needs will be met as well as the program's cost limit. In situations where the plan of services exceeds the 125% cost limit, the LAH Waiver Division works closely with the case management agency to troubleshoot available options; applicants are denied in cases where the plan of services cannot be brought within the program cost limits. Applicants who are denied receive a letter, inclusive of Fair Hearing and Appeal Rights, from the Division of Eligibility and Waiver Services.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☑ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Services may be approved up to 125% of the annual cost neutrality amount. These services are approved based on recommendations by the Adult Evaluation and Review Services, the contracted case management agency and the applicant. The LAH Waiver Division considers the degree of assistance an individual needs to live safely in the community, the availability of other resources to meet individual needs and any informal supports that may exist when making the decision to approve plans of service.

In addition, the program policy is also based on LAH participants requiring varying amounts of services. The Living at Home Waiver Division Fiscal Unit generates quarterly reports of the plans of service costs, based on actual paid claims, in order to monitor the costs.

Program trends inform that a high percentage of individuals transitioning to the community from nursing facilities require initial expenditures to facilitate a safe discharge. These items tend to be high dollar durable medical equipment for mobility, such as wheelchairs, funds for environmental accessibility adaptations including ramps, assistive technology expenses for environmental controls and transitional services. Conversely, other program trends show that many individuals have static costs that vary only when their informal supports change or progressive conditions become worse.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	765
Year 2	850
Year 3	944
Year 4 (renewal only)	1047

Year 5 (renewal only)	1162

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity

among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

In December of 2002 the Living at Home Waiver Program closed to new community applicants due to a lack of funding for new community applicants. In 2003 and 2004, the State passed legislation, Money Follows the Individual Act (MFIA) and Money Follows the Individual Accountability Act (MFIAA). Based on MFIA legislation, Maryland continues to allow eligible applicants from Nursing Facilities to apply for the LAH Waiver Program provided they reside in a Maryland Nursing Facility and their services are funded by Medicaid for 30 or more days. Additionally, the MFIAA legislation requires nursing facilities, the social worker, to provide information concerning home and community-based services programs and community options to nursing home residents at various times during their stay.

When LAH serves more individuals than approved by CMS through the application process, an amendment is submitted to CMS requesting approval for additional slots.

When funds become available as a result of legislation or the annual budget process, the LAH waiver will be able to accept additional community applications. When such funding is available, LAH accesses potential applicants from the program interest list, the Waiver Services Registry, in the order in which their names were placed on the list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- **100% of the Federal poverty level (FPL)**
- **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- **Medically needy in 209(b) States (42 CFR §435.330)**
- **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All other mandatory and optional groups under the plan are included.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- **A special income level equal to:**

Select one:

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- **A dollar amount which is lower than 300%.**

Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

[ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- ◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - ◉ **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  Select one:

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - **A percentage of the Federal poverty level**

    Specify percentage:
  - **Other standard included under the State Plan**

    Specify:
- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:
- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

  Specify the amount of the allowance (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

  [ ]

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

  [ ]
- **Other**

  Specify:

  [ ]

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  Specify:

  [ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

  Specify formula:
- **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- ( ) **The provision of waiver services at least monthly**
- (●) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Current program regulations require a program participant to use at least one waiver service annually in order to maintain program eligibility. Case managers are required to monitor program participants monthly through contacts and quarterly via face-to-face visits.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By an entity under contract with the Medicaid agency.**

Specify the entity:

The Department's contracted Utilization Control Agent (UCA) is responsible for initial and annual evaluations of Level of Care based on assessment information obtained by the Adult Evaluation and Review Service staff of the local health departments. Registered Nurses employed by the UCA review the documentation in order to

make a determination. Any denied level of care decision for a Living at Home Waiver participant is reviewed by the Medical Director of the UCA and a Medicaid physician advisor as needed.

- **Other**
  Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The UCA employs licensed registered nurses to determine LOC. The UCA employs a physician, as does DHMH, who will assist in the determination of LOC when there are unusually complex or contested decisions made by the nurse reviewers. All LOC determinations are subject to the review and approval by the Medicaid agency.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The Maryland Medicaid 3871B instrument is used to determine if an individual requires a nursing facility level of care. Individuals approved for a nursing facility level of care do not require hospital care, but have been determined to need supervision of licensed health care professionals as a result of mental or physical status; they may require skilled nursing care, rehabilitation services, health-related care and services, above room and board, on a regular basis, as well as related services. In addition, in July of 2008 updated guidance about interpreting Level of Care criteria were sent out to Medicaid providers.

In order to receive Medicaid benefits for services in a nursing facility or through the Living at Home Waiver, an individual must meet certain medical eligibility criteria. The specific qualifying criteria are set forth in both federal and State regulations. In interpreting these regulatory criteria, the Program will use the following guidelines. Nursing facility services are services provided to individuals who, because of their mental or physical condition, require 1) skilled nursing care and related services, 2) rehabilitation services, or 3) on a regular basis, health-related services above the level of room and board. These services are not intended to supplant services that are provided by a hospital, IMD, or ICF/MR.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The case management agency refers applicants and participants to the Adult Evaluation and Review Service program in the local health department to complete evaluations and re-evaluations for medical eligibility.

For initial evaluations and re-evaluations, the Adult Evaluation and Review Service (AERS) meets with the applicant or participant to request their permission to complete an evaluation for the Living at Home Waiver Program. After receiving consent, the AERS reviewer completes a record review and completes documentation, including the Maryland Medicaid 3871 B form. After completing this paperwork, AERs submits the 3871B documentation electronically to the contracted Utilization Control Agency for level of care determination. For initial applicants residing in nursing facilities, the AERs evaluator contacts the UCA for the most recent continued stay review dates that verify that the nursing facility level of care standard is met.

In July of 2008, DHMH began using a secure web-based participant tracking system to communicate information between agencies responsible for completing any portion of the initial or annual eligibility process. Presently, the

AERS units use the Living at Home tracking system to submit level of care determination requests to the UCA.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Until July of 2008, the Living at Home Waiver Division maintained an Access database and a spreadsheet to track annual redetermination information. In addition, the contracted case management entity maintains a separate tracking system for the purpose of ensuring timely redetermination.

In July of 2008, the Living at Home Waiver Division implemented an automated tracking system. This tracking system sends alerts to case managers 60 days prior to a participant reevaluation so that the process can begin. Reports are printed for DHMH staff so that they can track reevaluations to ensure they are timely.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Living at Home Waiver Division maintains hard copies of all evaluation and re-evaluation documentation for program applicants and participants on-site for five years. The contracted case management agency is also held to this same requirement. In addition, in July of 2008, the Living at Home Waiver Division implemented the use of a web-based tracking system that will house electronically retrievable documentation of eligibility determinations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Level of Care Determinations for community applicants for LAH will be completed by the UCA within 15 days of the date of referral. Numerator: Number of LOC determinations made for community applicants within 15 days of the date of referral. Denominator: Number of community applicants annually.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted Utilization Control Agency	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Level of Care determinations for individuals referred to LAH Waiver Program from nursing facilities will be confirmed within 15 days of the date of program referral. Numerator: Number of level of care confirmations completed within 15 days of applications (annually). Denominator: Number of annual nursing facility applicants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Hilltop Institute	☑ **Annually**

☑ **Continuously and Ongoing**
☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
All LAH program participants receive an annual Level of Care redetermination by the UCA. The contracted case management agency is responsible for initiating this process 60 days prior to the participant's annual waiver enrollment date by submitting a referral to AERS via the tracking system. Numerator:# of LOC determinations completed timely. Denominator: # of enrolled participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Contracted Case Management Agency	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
On a quarterly basis, the Office of Health Services monitors a sample of LOC determinations to ensure that an appropriate determination was made.
Numerator: # of LOC appropriate determinations Denominator: # of LOC determinations sampled

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The LAH Waiver Division began using a tracking system in July of 2008. The tracking system has the capability to provide reports on the time frames in which eligibility pieces, including are completed. One report is for timely LOC determination. If LOC determinations are not being completed timely, this information is reported to the UCA contract monitor. The contract monitor addresses the issue with the UCA to identify and resolve barriers to timely completion of the LOC.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

LAH staff track all LOC (initial & redeterminations) approvals & denial through the LAH tracking system. The Medical Care Specialist & Health Policy Analyst Associate is responsible for reviewing information in the tracking system on an on going basis. All participants who receive denial letters sent by DHMH have 30 days from receipt of the letter to appeal. All LOC denials are reviewed by SMA physicians

for accuracy & appropriateness prior to hearing. LAH staff refer problems to the appropriate authority. Example: If staff find a problem with timeliness of the redeterminations(annual LOC) for a participant involving the UCA then they will refer the issue to the SMA UCA contract monitor who will address the issue immediately with the UCA. The SMA UCA contract moniotr is responsible on an on-going basis for assuring that the UCA LOC determinations are as required.

LAH staff report LOC problems quarterly to the Waiver Quality Council. Recommendations and policy changes may be made based on data analysis. The UCA is responsible for submitting monthly & quarterly reports to the UCA contact monitor on LOC activities. The contract monitor shares the reports with all of the waiver programs. If issues are identified through this reporting system, the UCA contract monitor is responsible for working with the UCA to remediate the issues. The reportable events/complaints system is also used to identify and address LOC issues. LAH addresses all complaints. Reportable events & complaints are tracked through an RE tracking database. The Quality Assurance Specialist , on an on-going basis reviews and investigates all issues based on the reportable event policies & procedures. The LAH Division Chief & Deputy Director for Long Term care & Waiver Services are made aware by LAH staff of all LOC issues that can not be resolved timely.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the initial applicant meeting, the case manager is required to review the "Freedom of Choice" form indicating whether the applicant chooses, the "nursing facility," "the Living at Home Waiver program," or "Neither" option. The original signed "Freedom of Choice" forms are maintained at the office of the contracted case management agency for review, upon request, by the Living at Home Waiver Division. Information about the completion of these forms is communicated via the Living at Home tracking system. Case managers are also required to review the "Freedom of Choice" information annually with the participant. If the individual is not interested in reapplying for the LAH waiver program then the CM completes a new consent form indicating the individual's choice to decline services and documents the expressed reason for declining services

Additionally, the case managers provide applicants or potential applicants with detailed information about the services available under the waiver as well as resources and other services that may be available to meet their ongoing needs in the community.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the "Freedom of Choice" forms are available via the contracted case management agency for a minimum of five years. In addition, the Living at Home Waiver Program tracking system collects data about the completion of the "Freedom of Choice" form for reporting purposes.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to clients, and translations of forms and documents. Additionally, interpreter resources are available for individuals who contact DHMH for information, requests for assistance or complaints. LEP services are also available via program contractors.

The DHMH website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at fair hearings if necessary. If an LEP appellant attends a hearing without first requesting services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand and participate in the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Attendant Care**
Statutory Service	**Case Management**
Statutory Service	**Medical Day Care**
Other Service	**Assistive Technology**
Other Service	**Consumer Training**
Other Service	**Dietician Nutrition Services**
Other Service	**Environmental Accessibility Adaptation**
Other Service	**Environmental Assessment**
Other Service	**Family Training**
Other Service	**Home Delivered Meals**
Other Service	**Nursing Supervision**

Other Service	**Personal Emergency Response System**
Other Service	**Transition Services**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

Service Definition *(Scope):*

A "Unit of service" means an hour of service that is pre approved in the plan of service that is rendered to a participant by a qualified, enrolled attendant care provider in the participant's home or in a community setting. These services are normally ongoing and assist program participants with a variety of activities of daily living, instrumental activities of daily living and delegated nursing tasks. This includes, but is not limited to assistance with bathing, dressing, transfers, grooming, eating, using the bathroom, escorting participants to appointments, meal preparation, light housekeeping, and medication administration. Units of service may also fluctuate in amount, frequency and duration as the result of intermittent care needs including health status change, the availability of informal care providers or attendance to rehabilitative or medical appointments in the community.

There is currently two rates of payment; one for all Agency attendant care providers and one for all attendants under the non-agency model.

Living at Home Waiver attendant care services exclude services rendered to someone other than the identified participant, the cost of meals and/or food, housekeeping services (except where specified), room and board costs for the participant and/or the attendant or the expenses incurred while escorting a participant to a medical appointment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service may not exceed 23 units/hours in one day. LAH attendant care services are limited to the amounts, frequency and durations described in the pre-approved plan of services and may not be provided concurrent to the receipt of Medical Assistance Personal Care Program Services, Medical Day Care Waiver or skilled nursing services. Payment is rendered for services where the participant signs or otherwise verifies the work activities the attendant care provider completed.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	**Public or Private**
Individual	**Non-Agency (restricted)**

Individual	**Non-Agency Attendant Care (non-restricted)**
Individual	**Non-Agency (self-delegation)**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:
Agency

Provider Type:
Public or Private

Provider Qualifications

License *(specify):*
In order to participate as an agency provider of attendant care service an agency shall be a licensed home health agency or meet the criteria identified under "certificate." In addition, an attendant care agency must employ or contract with licensed Registered Nurses to monitor and supervise the activities of the attendant care employees.

Certificate *(specify):*
Attendant care agencies may also include providers certified by the Office of Health Care Quality as a residential services agency (RSA) or certified by the Department as a Medicaid personal care provider agency (MAPCSP), a Medicaid in home aide program (e.g. local health department), or a public or private agency which employs in-home attendants and has been approved by the Department of Human Resources and enrolled with the Medicaid program to provide attendant care services. Attendants employed by an agency are required to be certified in the performance of First Aide and CPR by a nationally recognized agency. Certified Nursing Assistant status may be required for activities that would normally be delegated by a nurse; or, if required to administer medications, be either a certified medicine aide in accordance with COMAR 10.39.03; or a Medication technician in accordance with COMAR 10.39.04.

Other Standard *(specify):*
Attendant care agencies enrolled with LAH Waiver Division must employ or contract with licensed Registered Nurses to monitor and supervise the activities of the attendant care employees. Agency attendant care providers are required to receive nursing supervision before rendering services to a LAH participant. LAH participants may not elect to waive any qualifications for agency attendants. Attendant care agencies are required to meet all licensing and/or certification standards mandated by the Office of Health Care Quality for RSA, Home Health Agency, etc; as specified by the Department for Medical Assistance Personal Care Services Program; and as specified by the Department of Human Resources for the In-Home Aid Service (IHAS).

Nurse supervisors must be available to give instructions to attendants and to answer questions during a normal working day, including having a nurse monitor available to respond to medical or health-related issues that are within the scope of the nurse's license, which may be raised by the participant, an attendant, the case manager/co-planner, or other individual involved in a participant's care. Attendant care agencies must keep accurate records including the plan of services, the participant assessment, the caregiver service plan, progress notes, reports, the name of the assigned attendant care provider, the duties performed, the dates and times services were rendered. Agencies are required to maintain 24-hour availability by beeper for emergencies; and submit written documentation of services on a form designated by the Department.
Agency attendant care providers must meet all requirements to enroll as an Agency attendant care provider. Agency attendants must be at least 18 years of age and be legally eligible for employment rendering attendant care services in the State. Agency attendants must be able to communicate, read, write, and follow directions in English. These attendants must receive instruction, training and assessment from the delegating nurse regarding all services identified in the plan of services.
Agency attendants shall receive instruction and supervision from the nurse monitor in accordance with the regulation requirements located at COMAR 10.09.55.25. Attendants who perform any delegated nursing tasks must hold current Certified Nursing Assistant status.
Agencies are required to maintain accounts with the Criminal Justice Information System (CJIS) in Maryland and must verify that all attendants have acceptable criminal backgrounds (see COMAR 10.09.55.06 requirements before assigning that staff member to work with a LAH participant. Attendants may not have been convicted of, received a probation before judgment for, or entered a plea of nolo contendere to, a felony or any crime involving moral turpitude or theft, or

have any other criminal history that indicates behavior which is potentially harmful to participants; attendants may not be cited on the Maryland Geriatric Nursing Assistants Registry or any other registries with a determination of abuse, misappropriation of property, or neglect. All LAH services providers must meet the "general requirements" for participation located at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Initially upon enrollment and quarterly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:
Individual

Provider Type:
Non-Agency (restricted)

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
Unless the participant elects to waive these requirements, non-agency attendants are required meet all criteria indicated in the non-restricted non-agency model of attendant care. Under this model, the participant (employer) signs a form indicating the specific provider requirements they are requesting to waive. This form is approved or denied by the Department; a copy is sent to the participant, any representative and their case manager. The original form is retained in the participant file at the Department.

Non-agency attendants who administer medications must be either a certified medicine aide in accordance with COMAR 10.39.03; or a Medication technician in accordance with COMAR 10.39.04; presently, this criteria may not be waived.

Other Standard *(specify):*
The minimum requirement for a non-agency attendant for whom their participant (employer) has waived criteria would be for them to be eligible for employment rendering attendant care services in the State. When the age limit is waived, the attendant may be no younger than 14 years old and they must have an approved work permit. Non-agency attendant care providers must keep accurate records to include the dates and times services were rendered as well as the duties completed during each shift. Attendants are required to follow the caregiver service plan written by the Nurse monitor. Participants supervise these attendant care providers.

When a participant requests to waive provider qualifications, including a criminal background investigation, CPR, First Aid, the age limit or the requirement to communicate in English, they submit a form to the Department for approval or denial. The form is then signed and returned to the participant with a summary of fair hearing rights. The Department retains the document in the participant file and mails or faxes a copy to the participant and the case manager.

When a participant elects to delay nursing supervision for 30 days, they submit a form to the Department. The form is approved or denied and is returned to the participant with a letter indicating the date by which the attendant must receive nurse supervision as well as a summary of fair hearing rights. The Department retains the document in the participant file and mails or faxes a copy to the participant and the case manager. Documentation about the completion of nurse supervision is forwarded to the Department via the assigned case manager. All providers must meet the "general requirements" located at 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and quarterly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:
Individual
Provider Type:
Non-Agency Attendant Care (non-restricted)
Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
Non-agency attendants must be certified in the performance of First Aid and CPR by a nationally recognized agency. Certified Nursing Assistant status may be required for activities that would normally be delegated by a nurse.; or, if required to administer medications, be either a certified medicine aide in accordance with COMAR 10.39.03; or a Medication technician in accordance with COMAR 10.39.04.

Other Standard *(specify):*
Non-agency attendant care providers are required to receive nursing supervision before rendering services to a LAH participant. Non-agency attendant care providers are required to pay for and complete a criminal background investigation with the Criminal Justice Information System (CJIS) in Maryland and must meet standards described in COMAR 10.09.55.06. Non-agency attendants may not have been convicted of, received a probation before judgment for, or entered a plea of nolo contendere to, a felony or any crime involving moral turpitude or theft, or have any other criminal history that indicates behavior which is potentially harmful to participants; attendants may not be cited on the Maryland Geriatric Nursing Assistants Registry or any other registries with a determination of abuse, misappropriation of property, or neglect. Non-agency attendants must be eligible for employment rendering attendant care services in the State. Non-agency attendants must be at least 18 years of age and be legally eligible for employment rendering attendant care services in the State

Non-agency attendants must be able to communicate, read, write, and follow directions in English. These attendants must receive instruction, training and assessment from the delegating nurse regarding all services identified in the plan of services. Non-agency attendants shall receive instruction and supervision from the nurse monitor in accordance with the regulation requirements located at COMAR 10.09.55.25. Certified Nursing Assistant status may be required for attendants performing delegated nursing activities. Non-agency attendant care providers must keep accurate records to include the dates and times services were rendered as well as the duties completed during each shift. Attendants are required to follow the caregiver service plan written by the Nurse monitor. Participants supervise these attendant care providers. In addition, all LAH services providers must meet the "general requirements" for participation located at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and quarterly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:
Individual
Provider Type:
Non-Agency (self-delegation)
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
Non-agency attendants who administer medications must be either a certified medicine aide in accordance with COMAR 10.39.03; or a Medication technician in accordance with COMAR 10.39.04; presently, this criteria may not be waived.
Other Standard *(specify):*
The minimum requirement for a non-agency attendant for whom their participant (employer) has waived criteria would be for them to be eligible for employment rendering attendant care services in the State. When the age limit is waived, the attendant may be no younger than 14 years old and they must have an approved work permit. Non-agency attendant care providers must keep accurate records to include the dates and times they rendered services as well as the duties completed during each shift. Attendants are required to follow the caregiver service plan written by the Nurse monitor. Participants supervise these attendant care providers.

The non-agency attendant working under the self-delegation model shall receive all instruction, supervision, assessment and evaluation from the participant (employer). Attendants working under the self-delegation model follow a caregiver service plan written by the participant.

Participants seeking to use self-delegation meet with their case manager to discuss their rights and responsibilities under this model. In order to use self-delegation, the participant must be cognitively capable and currently may not use an authorized representative or other third party to delegate on their behalf. The case manager seeks input from individuals in the participant's life and professionals who work with them (the current Nurse Monitor, Adult Evaluation and Review Service, etc). When all team members agree that the person is capable of self-delegation, they move forward with sending a written request to the Department for approval. The form is then signed and returned to the participant with a summary of fair hearing rights. The Department retains the document in the participant file and mails or faxes a copy to the participant and the case manager.

Participants who are interested, but not yet ready to self-delegate may also choose to receive support from a nurse monitor for a specified period of time. Use of self-delegation is documented in the plan of service and monitored by the case manager. The participant may choose to resume use of Nurse Monitoring at any time. Alternately, any team member with concerns about health and safety under the self-delegation model may request to review the participant's ability to continue to use this model.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and quarterly

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):

Service Definition *(Scope):*
LAH provides two components of case management as a waiver service. This includes transitional and ongoing case management. Transitional case management is provided for applicants, upon successful enrollment in the waiver from a nursing facility, for services rendered in the 180 days prior to community transition. This is a comprehensive service that assists LAH applicants, residing in nursing facilities prepare for independent community living. This service includes, but is not limited to, coordination of housing options; assisting

applicants in identifying and overcoming potential housing barriers; assistance in accessing Medicaid and non-Medicaid services by making referrals, providing information, or providing other assistance as requested by the individual. Ongoing case management includes making monthly contacts and quarterly face to face visits with program participants; ensuring delivery of all Medicaid and non-Medicaid services; monitoring service utilization of all waiver services; completing reportable event forms in accordance with the Department's policy. Ongoing case management consists of these same activities for LAH participants.
Initially,Upon enrollment and at least annually case managers provide information on self-direction opportunities to participants. This includes provider choice,non-agency attendant care, and self-direction of non-agency attendant care. Case managers assist participants with self-direction as requested and needed via monthly contacts and quarterly face-to-face visits. Level and type of assistance is based on individual participant needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transitional case management is provided to LAH applicants 180 days prior to discharge from a nursing facility.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Case Management
Provider Qualifications
License *(specify):*
Not required
Certificate *(specify):*
Not required
Other Standard *(specify):*
Case managers are required to meet the following minimum qualifications; Bachelor degree in a human services field, including psychology, social work, sociology, nursing, counseling, sociology, or a related field with work pertaining to adults with chronic conditions and disabilities. Note: The current contract permits any incumbent vendors to retain case management staff, employed prior to the implementation of these requirements,therefore, some case mangers may not meet the above qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:
The Living at Home Waiver Division
Frequency of Verification:
Upon identification and no less than annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Medical Day Care

Service Definition *(Scope):*

Medical day care means medically supervised, health-related services provided in an ambulatory setting to medically handicapped adults, who, because of their degree of impairment, need health maintenance and restorative services supportive to their community living. Medical day services are provided in accordance with physician's orders and the waiver plan of service, The Medical Day Care service may include medical, nursing, therapeutic or rehabilitative services, and psychosocial services. Transportation (to/from the Medical Day Care Program) and meals may be provided at the program and are included in the payment rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of time a participant spends in MDC is based on AERS recommendation and/or the participant's physician. MDC payments can not exceed $73.27 per day. A unit of service is no less than 4 hours a day. Units of service may not exceed what is approved in the participant's plan of service and may not be provided concurrent to attendant care service delivery.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Day Care

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Medical Day Care

Provider Category:

Agency

Provider Type:

Medical Day Care

Provider Qualifications

License *(specify):*

Providers are required to be licensed as a Medical Day Program in accordance with Office of Health Care Quality regulations for Medical Day Centers.

Certificate *(specify):*

N/A

Other Standard *(specify):*

In addition to requirements indicated above, LAH providers shall meet all conditions described under "general requirements" and located at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Health Care Quality and the Office of Health Services
Frequency of Verification:
Providers must meet all requirements prior to enrollment. The Office of Health Care Quality conducts annual surveys and The Office of Health Services performs on-going site visits of Medical Day Care Centers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Technology
Service Definition *(Scope):*
A unit is equal to one piece of equipment or item. Assistive technology is a device or appliance that empowers a participant to live in the community and/or participate in community activities with the highest degree of independence possible. Assistive technology may include a variety of environmental controls for the home or automobile, personal computers, software or accessories, maintenance ore repair of assistive technology devices, augmentative communication devices, self-help aids that assist with activities of daily living and/or instrumental activities of daily living. Additionally, assessments and training for may be included as costs under the Assistive Technology service. In order to qualify for payment, each piece of assistive technology shall meet applicable standards of manufacture, design, usage, and installation. Service animals and any experimental technology or equipment is excluded.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The payment rate for this service is up to $1,000.00 per unit or $6,246.66 per 12 month period. Cost cap includes both Environmental Accessibility Adaptations and Assistive Technology services. Case managers are required to obtain multiple quotes for individual units of service that exceed $1,000. Assistive technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare or the Medicaid State plan. LAH may approve services that exceed this cost cap under circumstances when there is documentation that the additional services will reduce the on-going cost of care or avert institutional care without exceeding the overall participant's cost neutrality as described in COMAR 10.09.55.28. Units of service may not exceed what is approved in the participant's plan of service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology
Individual	Non-Agency Assistive Technology

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Assistive Technology
Provider Qualifications
License *(specify):*
In accordance with Department of Labor and Licensing requirements, a Home Improvement License may be required to complete some Assistive Technology projects where an existing home structure is modified (such as a stair glide).
Certificate *(specify):*
N/A
Other Standard *(specify):*
To participate in the Program as a provider of assistive technology services, a provider shall: Be one of the following entities: The store, vendor, organization, or company which sells or rents the equipment or system; or a Program provider of disposable medical supplies and durable medical equipment.

The Assistive Technology providers shall provide or arrange for any installation, servicing, training, or monitoring required for the proper operation of the device or system.

Assistice Technology providers shall provide services in accordance with written estimated start and completion dates.

All LAH Waiver Division providers must meet the "general requirements" for provider participation located at COMAR 10.09.55.05.
Verification of Provider Qualifications
Entity Responsible for Verification:
LAH Waiver Division
Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Non-Agency Assistive Technology
Provider Qualifications
License *(specify):*
In accordance with the Maryland Department of Labor and Licensing requirements, a Home Improvement License may be required to complete some Assistive Technology projects where an existing home structure is modified (such as a stair glide).
Certificate *(specify):*
N/A
Other Standard *(specify):*
To participate in the Program as a provider of assistive technology services, a provider shall be a self-employed vendor that sells or rents the equipment or system; or a Program provider of disposable medical supplies and durable medical equipment.

The Assistive Technology providers shall provide or arrange for any installation, servicing, training, or monitoring required for the proper operation of the device or system.

Assistice Technology providers shall provide services in accordance with written estimated start and completion dates.
Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Consumer Training
Service Definition *(Scope):*
The definition of "Unit of service" regarding consumer training means an hour of service rendered one-on-one by a qualified provider to a participant, not including the time spent by the provider. Planning, preparing, or setting up the training or following up after the training. Consumer training includes instruction and skill building in such areas as how to recruit, select, train, direct, supervise, and fire consumer-employed attendants, as well as money management, budgeting,independent living, meal planning, and other areas specified in the participant's plan of service. The topics covered by consumer training shall: be specified in the participant's plan of service as necessary to safely maintain the participant at home; Be targeted to the individualized needs of the participant receiving the training; and be sensitive of the educational background, culture, and general environment of the participant receiving the training. Consumer training shall include updates as necessary to maintain or improve skills, if these updates are preapproved in the plan of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Units of service may not exceed what is included in the participant's approved plan of service and may not exceed 8 hours/units in any one day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Non-Agency Consumer Training
Agency	Consumer Training Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Training

Provider Category:
Individual
Provider Type:

Non-Agency Consumer Training

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
To participate in the Program as a provider of consumer training, a provider shall: Be a self employed individual provider of consumer training with demonstrated experience with the skill being taught; and be willing to meet at the participant's home to provide services. In addition, all providers must meet the conditions described in "general requirements" located at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Training

Provider Category:
Agency

Provider Type:
Consumer Training Provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
To participate in the Program as a provider of consumer training, a provider shall: Be an agency, that employs qualified trainers with demonstrated experience with the skill being taught; and be willing to meet at the participant's home to provide services. In addition, all providers must meet the conditions described in "general requirements" located at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Dietician Nutrition Services

Service Definition *(Scope):*
Dietitian and nutritionist services shall include the provision of nutrition care plan outcomes and approaches as

part of the waiver multidisciplinary team process; nutrition care planning, nutrition assessment, and dietetic instruction; and services within the scope of practice of the nutritionist's or dietitian's license, as defined by Health Occupations Article, Title 5, Annotated Code of Maryland; and Regulations under COMAR 10.56 for the Board of Dietetic Practice.

Dietitian and nutritionist services may not include services rendered on a group basis or in a classroom setting. The services shall be covered if the participant's medical condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian; targeted to the individualized needs of the participant, rather than being of general interest; sensitive to the educational background, culture, religion, eating habits, preferences, and general environment of the participant; and specified in the participant's plan of service as necessary to ensure the participant's health and safety; and prevent the participant's institutionalization or hospitalization.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This services is limited to 8 units/hours rendered in a day and may not exceed the units of service approved in the participant's plan of services. In addition, this service may not duplicate any service available through the participant's private insurance, Medicare or Medicaid State Plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dietician and Nutrition Provider
Individual	Non-Agency Dietician Nutrition Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietician Nutrition Services

Provider Category:
Agency
Provider Type:
Dietician and Nutrition Provider
Provider Qualifications
License *(specify):*
Agency providers shall be a licensed Professional group or agency which employs individual dietitian(s) or nutritionist(s) licensed in accordance with COMAR 10.56.01 and Health Occupations Article, Title 5, Annotated Code of Maryland.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Providers must meet conditions described as "general requirements" located at 10.09.55.05.
Verification of Provider Qualifications
Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dietician Nutrition Services

Provider Category:
Individual
Provider Type:
Non-Agency Dietician Nutrition Provider
Provider Qualifications
License *(specify):*
Providers shall be a self-employed dietitian or nutritionist who is licensed in accordance with COMAR 10.56.01 and Health Occupations Article, Title 5, Annotated Code of Maryland.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Providers must meet conditions described as "general requirements" located at 10.09.55.05.
Verification of Provider Qualifications
Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Accessibility Adaptation
Service Definition *(Scope):*
Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. All services shall be provided in accordance with applicable State or local building codes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service cost is limited to $6,246.66 per 12 month period and this cost cap includes both Environmental Accessibility Adaptations and Assistive Technology service. Exceptions to this cap are located at 10.09.55.28. Units of service may not exceed what is approved in the participant's plan of service. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. Adaptations to homes that are not owned by the participant require the owner's written permission.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Environmental Accessibility Adaptations
Individual	Non-Agency Environmental Accessibility Adaptations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:
Agency

Provider Type:
Agency Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*
Agency Environmental Accessibility Adaptations providers are required to be properly licensed by the State as a contractor, builder or possess a home improvement license depending on the scope of the specific work being completed for the participant.

Certificate *(specify):*
N/A

Other Standard *(specify):*
To participate in the Program as a provider of environmental accessibility adaptations, a provider shall: Be the store, vendor, or group of contractors, from which the adaptation is purchased; In addition they must provide or arrange for any required installation, servicing, or training; and Provide services according to a written schedule indicating an estimated start date and completion date. If construction is involved, the provider shall also meet the following requirements: Be properly licensed by the State as a contractor or builder; Be properly bonded; Agree to obtain all necessary State and local permits; Agree to ensure that the work passes the required inspections; and Agree that all work shall be performed in accordance with State and local building codes. In addition, providers must meet the conditions for "general requirements" as described at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living At Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:
Individual

Provider Type:
Non-Agency Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*
The provider must posses a contractor, builder or home improvement license in the State of Maryland depending on the scope of the specific work being completed for the participant.

Certificate *(specify):*
N/A

Other Standard *(specify):*

To participate in the Program as a provider of environmental accessibility adaptations, a provider shall be a self-employed contractor from which the adaptation is purchased; In addition they must provide or arrange for any required installation, servicing, or training; and Provide services according to a written schedule indicating an estimated start date and completion date. If construction is involved, the provider shall also meet the following requirements: Be properly licensed by the State as a contractor or builder; Be properly bonded; Agree to obtain all necessary State and local permits; Agree to ensure that the work passes the required inspections; and Agree that all work shall be performed in accordance with State and local building codes. In addition, providers must meet the conditions for "general requirements" as described at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Assessment

Service Definition *(Scope):*
Environmental Assessment is the completion of an on-site environmental assessment of a home or residence where the participant lives or will live as a participant; and a form approved by the Program.

An environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services.

The service may be recommended by a multidisciplinary team in the plan of service for a participant when an environmental assessment is considered necessary to ensure the health and safety of a participant with special environmental needs; and obtain additional professional advice from an occupational therapist about the physical structure of a participant's home or residence; and functional or mental limitations or disabilities of a participant as they relate to the environment.

Included in the environmental assessment, as necessary, may be an evaluation of the presence and likely progression of a disability or a chronic illness or condition in a participant; environmental factors in the facility or home; the participant's ability to perform activities of daily living; the participant's strength, range of motion, and endurance; the participant's need for assistive devices and equipment; and the participant's, family's, or service provider's knowledge of health, safety, and stress reduction factors.

Based on an inspection of the home and interviews with the participant, family, or service provider, the provider shall complete a form, to be reviewed by the case manager, which details the provider's findings and recommendations, especially relating to a participant's need for the waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Assessment is capped at 395.59 per assessment and is limited to one assessment annually. Units of service may not exceed what is approved in the participant's plan of service and may not duplicate any service that is available through private insurance, Medicare or the Medicaid State Plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Environmental Assessment Provider
Individual	Non-Agency Environmental Assessment Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:
Agency

Provider Type:
Agency Environmental Assessment Provider

Provider Qualifications

License *(specify):*
To participate in the Program as a provider of environmental assessments, a provider shall be an agency or professional group employing a licensed occupational therapist.

Certificate *(specify):*
N/A

Other Standard *(specify):*
To participate in the Program as a provider of environmental assessments a provider shall: Receive a referral from the participant's case manager, based on services pre authorized in the plan of care; and Document the provider's findings and recommendations on a form approved by the Program. In addition, providers must meet the conditions described at COMAR 10.09.55.05 under "general requirements."

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:
Individual

Provider Type:
Non-Agency Environmental Assessment Provider

Provider Qualifications

License *(specify):*
To participate in the Program as a provider of environmental assessments a non-agency provider shall be a licensed occupational therapist.

Certificate *(specify):*
N/A

Other Standard *(specify):*
To participate in the Program as a provider of environmental assessments a provider shall: Receive a referral from the participant's case manager, based on services pre authorized in the plan of care; and Document the provider's findings and recommendations on a form approved by the Program. In addition, providers must meet the conditions described at COMAR 10.09.55.05 under "general

requirements."

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Family Training

Service Definition *(Scope):*
Family Training as a "Unit of service" means an hour of service rendered by a qualified provider to one or more family members at the same time in the participant's home or the provider's office, regardless of the number of family members trained at one time, not including the time spent by the provider; planning, preparing, or setting up the training; or following up after the training.
"Family member" means an individual who; lives with or provides assistance to the participant; and is not paid to provide the care.
Family training includes instruction about treatment regimens and the use of equipment specified in the plan of service.
The topics covered by family training shall be specified in the participant's plan of service as necessary to safely maintain the participant at home; targeted to address the individualized needs of the participant whose family member is receiving the training; and sensitive of the educational background, culture, and general environment of the family member receiving the training.
Family training shall include updates as necessary to continue to safely maintain the individual at home, provided these updates are preapproved in the plan of service. There are two types of service providers; agency and non-agency as well as corresponding rates for services delivered.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service may not exceed eight units/hours per day and may not exceed the number of units included in a participant's approved plan of service. In addition, this service may not duplicate any other service that may be available through private insurance, Medicare or the Medicaid State Plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Family Training
Individual	Non-Agency Family Training

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Agency

Provider Type:
Agency Family Training

Provider Qualifications

License *(specify):*
An agency which employs or contracts with licensed professionals including licensed Registered nurse(s) or nurse practitioner(s), licensed Occupational therapist(s), licensed Speech pathologist(s) or licensed Physical therapist(s.

Certificate *(specify):*
N/A

Other Standard *(specify):*
All LAH providers must meet the conditions for participation described as "general requirements" in COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual

Provider Type:
Non-Agency Family Training

Provider Qualifications

License *(specify):*
To participate in the Program as a provider of non-agency family training services, a provider shall be one of the following self-employed professionals: A licensed Registered nurse or nurse practitioner; A licensed Occupational therapist; licensed Speech pathologist or a licensed Physical therapist.

Certificate *(specify):*
N/A

Other Standard *(specify):*
All LAH providers are required to meet the conditions described as "general requirements' locate at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

Service Definition *(Scope):*

Home Delivered meals shall be intended for consumption at home; each meal shall be nutritionally adequate for the participant's age based on the Recommended Dietary Allowance (RDA) or Dietary Reference Intake (DRI), as established by the Food and Nutrition Board of the National Research Council; and meet either of the following; at least 1/3 of the RDA or DRI; or therapeutic or restrictive diet requirements ordered by the participant's physician, dietitian, or nutritionist, including any ordered nutritional supplements.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Up to two meals per day, daily may be provided. Units of service may not exceed what is included in the participant's approved plan of service, may not provide full nutritional requirements and may not duplicate any services available through private insurance, Medicare, or the Medicaid State Plan. The Program's coverage under this regulation may not result, either alone or when combined with home-delivered meals received under Title III of the Older Americans Act, in public funding for the participant's full daily nutritional regimen of three meals; or supplant payment for home-delivered meals under Title III.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Home Delivered Meal Provider
Individual	Non-Agency Home Delivered Meals Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency Home Delivered Meal Provider

Provider Qualifications

License *(specify):*

An agency with a food service license issued by the local health department or an appropriate license from the state in which the site is located; and is approved for each licensing renewal based on inspections performed by State sanitarians, or by the licensing authority in the state in which the site is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Home Delivered Meal providers are required to be approved and monitored by the Department. All LAH providers must meet the conditions for provider participation located at COMAR 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home Waiver Division

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Individual
Provider Type:
Non-Agency Home Delivered Meals Provider
Provider Qualifications
License *(specify):*
Non-agency home delivered meal providers are required to hold a food service license issued by the local health department or an appropriate license from the state in which the site is located; and is approved for each licensing renewal based on inspections performed by State sanitarians, or by the licensing authority in the state in which the site is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Home Delivered Meal providers are required to be approved and monitored by the Department. All LAH providers must meet the conditions for provider participation located at COMAR 10.09.55.05.
Verification of Provider Qualifications
Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Nursing Supervision
Service Definition *(Scope):*
A nursing supervision "Unit of service" means an hour of service rendered one-on-one by a nurse monitor for a participant in the participant's home or another community-based setting where attendant care services are received. Nursing supervision services include the following nursing services provided in conjunction with a visit to the participant, if specified in the participant's plan of service and rendered by a licensed registered nurse or nurse practitioner: Development of the plan of care, rendering a professional evaluation, and B(2) of this chapter, of a prospective consumer-employed or agency-employed attendant's ability to understand and perform duties in accordance with COMAR 10.09.55.06A(4) and carry out the participant's specific plan for attendant care. Providers document an action plan to address all health and safety or medical concerns, including missed nursing supervision visits, and providing a copy of this to the case management agency within 5 business days. There are two models of this service available to LAH participants; the agency and the non-agency model; these are reimbursed at different rates with a higher rate paid to the agency to incorporate costs for overhead.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
One hour of service is equal to one unit. Services may not be provided in excess of eight units/hours per day and may not exceed what is approved in the participant's approved plan of service. The services covered under this regulation may not include nursing services other than those services described in this regulation and may

not duplicate services, such as home health or skilled nursing that may be available through private insurance, Medicare, the Medicaid State Plan or Early and Periodic Screening and Diagnostic Services (for individuals who are 18-21).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Nursing Supervision
Individual	Non-Agency Nursing Supervision

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nursing Supervision

Provider Category:
Agency
Provider Type:
Agency Nursing Supervision
Provider Qualifications

License *(specify):*
Nurse supervision providers must meet requirements and be currently licensed as a Registered Nurse or Nurse Practitioner.

Certificate *(specify):*
Nurse supervision agencies must be a) A public or private agency which has been approved by the Department of Human Resources, in accordance with COMAR 07.06.12; or (b) A Medicaid provider of: (i) Home health services under COMAR 10.09.04; or (ii) Personal care services under COMAR 10.09.20; or (c) A residential services agency certified in accordance with COMAR 10.07.05

Other Standard *(specify):*
Agencies enrolled with LAH to provide Nurse Supervision shall be one of the following:
An agency or clinic which employs registered nurses or nurse practitioners licensed according to COMAR 10.27.01 and 10.27.07; or ; (2) Employ or contract with attendants, who meet the requirements in §§A—C of this regulation, in sufficient numbers to ensure that a qualified attendant is available to provide the attendant care services ordered in the plan of service according to the schedule specified for each participant who receives attendant care services from an attendant employed by the attendant care provider agency;
(3) Supervise each attendant who is employed by or under contract with the attendant care provider agency;
(4) Employ or contract with licensed registered nurses to act as nurse monitors and provide nursing supervision, in accordance with Regulations .14 and .25 of this chapter, in sufficient numbers to ensure that a nurse monitor is available to provide the necessary type and frequency of nurse monitoring services required for each attendant rendering services;
(5) Be available to give instructions to attendants and to answer questions during a normal working day, including having a nurse monitor available to respond to medical or health-related issues that are within the scope of the nurse's license, which may be raised by the participant, an attendant, the case manager/co-planner, or other individual involved in a participant's care;
(6) Keep accurate records on each participant receiving attendant care services from the agency, which contain:
(a) The plan of service;

(b) Identification of each attendant providing services to the participant;
(c) Dates and times when attendants worked;
(d) Tasks they performed;
(e) Nurse monitors' instructions to the attendants; and
(f) Progress notes and observations on the attendant and the participant;
(7) Keep records and submit reports as required by the Department;
(8) Maintain 24-hour availability by beeper for emergencies; and
(9) Submit written documentation of services rendered to each participant as required by the Program and on a form designated by the Department.

Nurse supervisors must be willing to delegate nursing tasks to unlicensed, certified individuals; agree to maintain detailed, written documentation of services rendered to participants including progress notes and service outcomes, as specified by the Department. A provider shall ensure that a nurse monitor is available to provide the nursing supervision services. To participate in the Program as a provider of nursing supervision of attendants, a provider shall be: A self-employed licensed registered nurse or nurse practitioner. An agency or clinic which employs licensed registered nurses or nurse practitioners. The registered nurse or nurse practitioner who renders nursing supervision services shall be an individual who is: Self-employed; or Employed by or under contract with an agency; Meet the requirements of the Maryland Board of Nursing regarding nursing services and delegation of nursing functions.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Initially upon enrollment and quarterly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nursing Supervision

Provider Category:
Individual
Provider Type:
Non-Agency Nursing Supervision
Provider Qualifications

License *(specify):*
Nurse supervision providers must be a licensed Registered Nurse of Nurse Practitioner
Certificate *(specify):*
N/A
Other Standard *(specify):*
Nurse supervisors must be willing to delegate nursing tasks to unlicensed, certified individuals; agree to maintain detailed, written documentation of services rendered to participants including progress notes and service outcomes, as specified by the Department. A provider shall ensure that a nurse monitor is available to provide the nursing supervision services. To participate in the Program as a provider of nursing supervision of attendants, a provider shall be: A self-employed licensed registered nurse or nurse practitioner. An agency or clinic which employs licensed registered nurses or nurse practitioners. The registered nurse or nurse practitioner who renders nursing supervision services shall be an individual who is: Self-employed; or Employed by or under contract with an agency; Meet the requirements of the Maryland Board of Nursing regarding nursing services and delegation of nursing functions. Must meet the conditions described as "general requirements" under 10.09.55.05.

Verification of Provider Qualifications

Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and quarterly

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System

Service Definition *(Scope):*

A personal emergency response system is an electronic device, piece of equipment or system which, upon activation, enables a participant to secure help in an emergency 24 hours per day, seven days per week. There are a variety of devices and systems available to meet individual needs and preferences of LAH participants choosing this service. PERS may be used in the home exclusively or in the home and community; some models offer Global Positioning Systems technology to access assistance in a multiple community settings. Likewise, modes of access to the PERS monitoring system are adapted to meet the individual functional needs of the participant; for example, providers offer sip/puff models, push button access and modifications of push button models. This service may include any or all of the following components: purchase/installation; maintenance/ repair; and/or the monthly cost of monitoring a PERS device. There are different rates established for each of the three components of the PERS service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is a one unit maximum annually for installation; there is no maximum for maintenance; and there is a one unit maximum per month for PERS monitoring;. There are maximum fees established for each PERS component. Units for each type of service are identified separately in the participant's plan of service; units submitted for payment may not exceed what is approved in the participant's plan of service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency PERS Provider
Individual	Non-Agency PERS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:

Agency

Provider Type:

Agency PERS Provider

Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
To participate in the Program as a provider of personal emergency response systems, a provider shall: Be the store, vendor, organization, or company which sells, rents, installs, services, or runs the device or service; Provide or arrange for any installation, servicing, training, or monitoring required for the device or system; and Assure that any response center is: Responsible for monitoring or responding to a notification of an emergency by the system; and Adequately staffed 24 hours a day, 7 days a week by properly trained staff. In addition, providers must meet the conditions described in COMAR 10.09.55.05 under "general requirements."

Verification of Provider Qualifications
Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Individual
Provider Type:
Non-Agency PERS Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Be the a self-employed vendor which sells, rents, installs, services, or runs the device or service; Provide or arrange for any installation, servicing, training, or monitoring required for the device or system; and Assure that any response center is: (1) Responsible for monitoring or responding to a notification of an emergency by the system; and (2) Adequately staffed 24 hours a day, 7 days a week by properly trained staff. All providers must meet the conditions described at COMAR 10.09.55.05 as "general requirements."

Verification of Provider Qualifications
Entity Responsible for Verification:
Living at Home Waiver Division
Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transition Services

Service Definition *(Scope):*
Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution to a private residence where the individual is directly responsible for his or her living expenses. The goal is to assist the individual in setting up their household when they lack individual or community resources to obtain basic household goods. Allowable expenses that do not constitute room and board, may include the following:

Security deposits to obtain a lease on an apartment or home
Essential furnishings and moving expenses
Set-up fees for access or deposits for essential utility services
Services necessary for the individuals health and safety such as pest eradication
Transition Services must be reasonable and necessary as determined through the plan of care process and may not include monthly rental or mortgage expenses, food, regular utility costs, food and or items used for solely recreational purposes. Transition Services must be identified in the plan of care and rendered by a qualified provider and may not duplicate an other waiver or non-waiver Medicaid services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This is a one time service available to participants enrolling from nursing facilities. A unit of service refers to a an item that is
(1) Not otherwise available under the waiver;
(2) Approved in the plan of service; and
The cost cap is $3,000. (for all individual units) payable to the provider after transition has taken place. Providers may not be reimbursed for expenditures that are outside the scope of this services or for applicants who do not enroll in LAH Waiver Program. This is a direct reimbursement only and the provider does not receive an administrative payment for this service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Services

Provider Category:
Agency
Provider Type:
Agency
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
To participate in the Program as a provider of transition services a provider shall have experience in: Assisting individuals to transition from a nursing facility to a community-based residence; and arranging and coordinating the services necessary to facilitate the transition.
Verification of Provider Qualifications
Entity Responsible for Verification:
Living at Home Waiver Division

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Transitional and on-going case management (see service definitions) is provided by an entity identified through a competitive solicitation process and operates in conjunction with the provisions established under a 1915(b)(4) waiver approved on 11/1/2009. Administrative case management is not a waiver service and is provided by the same case management entity. This type of case management is limited to "activities required for Medicaid's proper and efficient administration." Case managers do not assist applicants with accessing non-waiver services and housing. Case managers receive payments to assist pending applicants with the waiver application and eligibility process including obtaining required documentation. In addition, the case managers coordinate activities for an evaluation of need by local health department staff, confirm applicant's certification status, and provide appropriate documentation to LAH program staff.
Case managers provide applicants with information about self-direction opportunities during the plan of service process. This includes provider choice and use of the non-agency model of attendant care.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Providers of attendant care services are required to submit to a criminal background investigation through the Maryland Criminal Justice Information System (CJIS) within the Division of Public Safety. These investigations are limited to the State. Attendant care agencies are required to maintain accounts in order to receive criminal background investigation updates in the event that an employee is convicted of a crime after employment. Unless this requirement is waived, LAH must receive results of the CJIS background investigation and they must be within limits identified in COMAR 10.09.55.06 prior to the provider applicant

being enrolled. Enrolled attendant care agencies are required to ensure that their attendants meet the applicable standards prior to working with LAH participants. LAH conducts on-site audits of agencies to verify that this is occurring. Maryland legislation has been passed that prohibits the release of criminal background information by third party entities; LAH is unable to obtain copies of the CJIS reports completed for agency providers. Participants using the non-agency model of attendant care services may request to waive this requirement; this is subject to the approval of the Department.
LAH requires the contracted case management provider to perform a screening of all staff who work directly with participants.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ( ) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- (●) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed

to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

The Department allows the participant's parents to enroll as providers of non-agency attendant care services; participants between the ages of 18 and 21 who enrolled would fall into this category. LAH does not allow a spouse to be a paid attendant care provider. All attendant care providers are required to complete a billing form (DHMH 248) and caregiver service report. The caregiver service report details the dates and times worked and the activities completed by the provider; it can be used to ensure that duties correspond to services the Nurse Monitor included in the caregiver service plan. Payments to all non-agency providers are made by the fiscal intermediary contractor. In this role, the contractor is responsible for reviewing all forms, comparing them for internal consistency and against the service authorization provided by the Department. These forms are again reviewed by the Department when they are entered in MMIS. These providers are monitored by a Nurse Supervisor at a frequency no less than every 45 days. Case managers are responsible for monitoring service delivery; reportable events are completed in situations where there is suspicion of fraud or exploitation.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

With the exception of spouses, the waiver makes payment to all types of family members and/or legal guardians who enroll to provide non-agency attendant care.

All non-agency providers are limited to performing 40 or less hours of services to participants.

While individuals may require a legal guardian, many of them are able to express preferences about care giving and the provision of other service delivery. There are times when a guardian may want to provide services and the participant disagree. In other situations, the participant is not able to express their choice or the case manager has concerns about the guardian's ability or intentions regarding performance of care. The case manager is responsible for evaluating the situation, obtaining input from the AERS evaluator, the Nurse Monitor and other involved parties in order to make a recommendation to the LAH Waiver Division. This information is taken into account during the POS review process in order to determine if the participant's interests are represented by the decisions made by the guardian. If performance of duties is an issue, additional Nurse Monitor services may be added to the plan. In other cases, use of alternate providers is recommended. The case manager and assigned Nurse Monitor are responsible for on-going contact and informing LAH Waiver Division about any concerns related to care. LAH Waiver Division is required to investigate and make decisions about the ability of the waiver program to safely serve program participants in the community.

All attendant care providers are required to complete a billing form (DHMH 248) and caregiver service report in order to verify the activities completed and the hours the attendant worked. The fiscal intermediary contractor makes payments to all non-agency providers. In this role, the contractor is responsible for reviewing all forms, comparing them for internal consistency and against the service authorization provided by the Department. The Department again reviews these forms when they are entered in MMIS. The billing forms may be used as monitoring tools to ensure that the attendant completes all duties indicated by the Nurse Monitor in the Caregiver Service Plan; this provides some degree of assurance that the participant's needs are met through service delivery. Case managers are responsible for monitoring service delivery; reportable events are completed in situations where there is suspicion of fraud or exploitation.

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Living at Home Waiver program accepts provider applications on an ongoing basis. Requests for provider applications may be made via phone, fax or email, and the "Provider Application Request Form" may be down loaded from the Department of Health and Mental Hygiene website and faxed to the Living at Home Waiver program. The Living at Home Waiver Division has a staff person assigned to review and certify provider applications.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PERCENT OF PROVIDERS WHO INITIALLY MEET LICENSURE AND/OR CERTIFICATION STANDARDS; Numerator: Total # of providers requiring licensure and/or certification who enroll as waiver providers (meet requirement); Denominator: Total # of providers requiring licensure and/or certification who submitted a provider application.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PERCENT OF PROVIDERS WHO MEET ONGOING LICENSURE AND/OR CERTIFICATION STANDARDS; Numerator: The Number of providers who qualify to maintain enrollment after post-enrollment review by LAH staff of credentials. Denominator: the Number of providers reviewed for qualifications.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Internal Access Provider Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PERCENT OF PROVIDERS WHO MEET LICENSURE AND/OR CERTIFICATION STANDARD DURING AUDIT PROCESS. Numerator: Total number of of providers, who require licensure and/or certification to perform services, meeting standards during audit; Denominator: Total number of providers audited who require licensure and/or certification to perform services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number of months in a year that a participant received a monthly contact call from their case manager per established procedure. Numerator: The number of months a participant is contacted by their case manager. Denominator: The number of telephone contact months required in a year. Note: Face to face visits happen on a quarterly basis and are captured separately.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of quarterly visits a participant has annually with their case manager based on established procedures. Numerator: Number of quarterly visits participants receive annually from their case manager. Denominator: The number of months per year quarterly visits are scheduled and completed (4).

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% Confidence level
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Case Management provider	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of unlicensed/uncertified providers meeting enrollment criteria at annual review. Unlicensed providers shall meet specific criteria for waiver service categorys; LAH Waiver Div. reviews criteria no less than annually. Numerator: Number of unlicensed waiver providers meeting criteria at annual review. Denominator: Total number of unlicensed waiver services providers at annual review.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of unlicensed and uncertified providers who meet criteria upon enrollment to the Living at Home Waiver Division. Numerator: Number of unlicensed and uncertified providers who enroll to provide services as a result of meeting provider requirements. Denominator: Number of applications for unlicensed and uncertified providers received at Living at Home Waiver Division.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Department will be making regulation changes in FY 2011 to require minimum annual provider training. Numerator: Number of providers completing annual required training. Denominator: Total number of enrolled providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Internal training records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Living at Home Waiver will be increasing provider training requirements (through regulation changes in FY 2011) and developing updated provider trainings over the next year.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Provider problems are identified through reportable events, complaints, provider service reports, provider claims, provider credential reviews, desk audit reviews of provider credentials and on-site provider audits. The provider specialist is responsible for these activities.
a. PM 1 Inital provider applications are reviewed by the provider specialist; this person returns all applications lacking required documentation along with a letter of explanation about how to enroll. Provider applications are closed if they do not return documentation within six months.
PM 2 Providers requiring licensure are reviewed no less than annually; Nurse monitor providers are reviewed no less than quarterly. The provider specialist runs a report and sends credential requests to providers lacking documentation on a quarterly basis; providers who fail to submit credentials within identified time frames are disenrolled from providing services.
PM 3 If providers lack documentation upon audit, they are provided with a time frame by which they must submit information. Unreponsive providers are disenrolled as LAH Waiver providers.

When program issues are identified, the LAH Waiver Division will refer the problem to the individual assigned to that area (see title and function list below). Generally, the staff person will immediately identify the impact of an issue and refer to staff for resolution as follows:
Quality of Care Issues to include reportable events, critical incidents, complaints, neglect, abuse, service delivery interruption-Quality Assurance Specialist, Medical Program Supervisor and Division Chief. The Quality Assurance Specialist is responsible for requesting corrective and preventative action plans from providers for who the Department has received complaints. The Provider Specialist, who is responsible for the day-to-day provider enrollment activities including initial credential verification, is responsible for generating quarterly and annual reports; these reports are the basis for requesting updated provider credentials as needed. When providers do not meet the intial qualifications, they are not able enroll and provide services. The Provider Specialist sends a letter requesting any outstanding itemsletters requesting updated credentials and terminating providers who fail to complete updates.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ○ **No**
- ◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

c. ii. In FY 2011 LAH staff will submit regulation changes to increase the provider training requirements.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ◉ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Service (POS)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The case managers are responsible for service plan development.
Based on the current contract case managers are required to meet the following minimum qualifications; Bachelor degree in a human services field, including psychology, social work, sociology, nursing, counseling, sociology, or a related field with work pertaining to adults with chronic conditions and disabilities. Note: The current contract still permits any incumbent vendor to retain case management staff, employed prior to the implementation of these requirements,therefore, some case mangers may not meet the above qualifications.

☐ **Social Worker.**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The only service where this applies is the Transitional Service. The Case Management Agency is required to provide this service. There is no payment for administering this service; it is a reimbursement of cost only, so there is no concern that the units of service would be artificially inflated.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a)Case managers, participants, their friends and family members are the central members of the team developing the POS, and are provided with written and/or oral information about LAH services and the process of developing a POS tailored for the individual. Participants have the support of a case manager to assist them by facilitating the planning meeting and assisting in the creation of the POS.

(b)Applicants and participants receive information from case manager about their right to invite family members, friends, professionals, and anyone else they desire to be part of team meetings and/or their circle of support, and are encouraged to involve important people in their lives in the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)Several entities are involved in the development of the POS with the applicant or participant, including the case management agency and the local health department AERS evaluators. The process is initiated by the LAH case manager(CM)after the applicant has received an application for enrollment from DHMH.

(b) After receiving a referral, AERS staff schedule an on-site visit with the applicant to conduct a comprehensive evaluation. AERS staff then conduct a multidisciplinary assessment within 10 days of the evaluation. Recommendations are made based on the comprehensive evaluation/assessment. The recommendations are shared with the case manager (CM). The CM schedules and completes a face-to-face meeting with the participant to explore the participant's needs, preferences and goals. If a participant is transferring from a nursing facility, discharge information will be available about the participant's health status and follow-up issues. The CM ensures that the applicant or participant has a current, signed release of information form allowing them to contact relevant parties on their behalf.

(c) In the initial meeting between the CM and the participant, the CM provides the participant with detailed information about all LAH waiver services.

(d) The plan of service development process ensures the participant's needs and preferences are addressed because the participant is involved in the entire plan of care development. The waiver POS lists the type, amount, frequency, cost, duration, and provider for all waiver, State Plan, community-based and informal services.
The participant is asked to sign the POS; therefore, any participant concerns would have to be addressed before the plan could be considered final.

(e) The CM is responsible for the coordination of waiver and other services to ensure the participant's needs and interests are addressed. The participant may opt to participate in the coordination activities.

(f) The interactive nature of planning for consumer-directed services effects the assignment of responsibilities as the POS is developed. As the participant makes known the extent of self-directed services they are interested in, the POS will naturally reflect the shared responsibilities of the participant and the CM. The participant and CM will communicate a minimum of once a month, and monitoring occurs as they discuss the participant's services, needs and preferences. Additionally, the CM and participant will have a face-to-face meeting every three months which is also part of the monitoring process.

(g) The POS must be updated at least annually but more frequently if the participant's status or needs change. The monthly communication and every three month face-to-face meeting enable changes to be implemented in the POS in a timely manner.

The CM works with the participant to develop a waiver POS, coordinate the delivery of waiver services in accordance with the POS, and to update the POS as necessary. Upon receiving the AERS evaluation and approved LOC for an applicant or participant, the CM conducts a face-to-face meeting with the applicant or participant to begin to develop their POS. The waiver POS lists the type, amount, frequency, cost, duration, and provider for all waiver, State Plan, community-based and informal services. If authorized by the participant, the CM may also contact the individual’s authorized representatives, family members, informal supports, NF staff, to determine needs and available supports for the POS. Additionally; the case management agency employs a nurse consultant specifically for the LAH waiver to answer questions or concerns of a clinical nature.

The CM provides each applicant and participant with the current DHMH LAH provider listing in order to facilitate the participant’s choice of providers. The CM is responsible for on-going monitoring of the POS to ensure that it is cost neutral and continues to meet the participant’s needs. The POS may be updated any time the participant’s needs change. On an annual basis, the CM coordinates the annual reassessment of participant eligibility which includes updating the POS. AERS staff performs an evaluation as part of the annual reassessment and recommends services to address the participant’s needs.

The CM tracks the eligibility process by using a tracking form which documents current information about waiver applicants and participants. The data collected on the tracking form is used to track time frames for eligibility determination requirements, including the development and implementation of the initial and annual POS.

The CM's tracking form is an internal database within the CM contractor. In addition to using their tracking form, the CMs are required to use the LAH web-based tracking system.

The Living at Home Waiver Tracking System is designed to electronically store clients’ most up-to-date waiver information, including diagnosis, plan of service information, case management notes, and referral creation and approval information. The Living at Home Waiver Tracking System provides a centralized task oriented web-based system to track applicants and participants that will present stakeholders with real time access to information, streamline enrollment and standardize forms and processes. The Living at Home Waiver Tracking System will function as a management tool increasing efficiency and accountability. Users will have the capability to view client history identifying key dates of the enrollment process and documentation. Examples of documentation include eligibility letters, narrations, ATPs, LOCs, POS just to name a few. Documents can be submitted with the click of a button, decreasing the need to fax and mail documents. Due to the fact that the system is task oriented all users are guided through the same eligibility steps using the same forms. The Living at Home Tracking System has the capability to provide various reports, alerts users of cases needing action or determinations made.

LAH staff reviews 100% of all POS and POS modifications prior to approval. LAH staff ensures that the applicant or participant (or representative)sign the POS indicating their agreement with the services; that services are consistent with the AERS recommendations for health and safety; that there is documentation to explain situations where a POS deviates from the AERS recommendations; that all informal care provisions are documented; that the POS cost, inclusive of State Plan and waiver services, is within the current cost neutrality amount.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As part of the participant's POS, the individual's health and safety needs are evaluated by the case manager. Risk mitigation strategies, including back-up plans that are based on the unique needs of the individual, and must ensure health and safety while affording an individual the dignity of risk. Individualized risk mitigation strategies are incorporated directly into the POS and are done in a manner sensitive to the individual's preferences. The plan of service will not be approved by LAH staff unless the individual's POS contains a reasonably designed back-up system for emergencies, including situations in which a scheduled employee does not show up to provide services. Risk mitigation strategies may include individual, family, and staff training, assistive technology, back-up staffing, etc.

In addition, all LAH agency attendant care service providers must have a system for providing emergency back-up services and supports in the event that scheduled employees are absent.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The case manager assists the individual in selecting his or her community provider agency. Both the individual and case manager can access a current listing of licensed providers offering services which is maintained by LAH provider specialist. Participants are encouraged to consider multiple providers and meet and interview staff prior to selection in order to make an informed choice. Once the participant has chosen his or her provider agency, the case manager will place the chosen provider into the participant's POS for a predetermined frequency of visits.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

LAH staff reviews 100% of all POS and POS modifications prior to approval. LAH staff ensure that the applicant or participant (or representative) sign the POS indicating their agreement with the services; that services are consistent with the AERS recommendations for health and safety; that there is documentation to explain situations where a POS deviates from the AERS recommendations; that all informal care provisions are documented; that the POS cost, inclusive of State Plan and waiver services, is within the current cost neutrality amount.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The case manager is responsible for monitoring the implementation of the plan of services including waiver and non-waiver services and assuring that the participant has a workable back-up plan. In addition the case manager ensures that the participant's health, safety and welfare needs are being met during monthly contacts and quarterly face-to-face visits. Case managers also monitor service implementation by contacting service providers when a participant or authorized representative reports problems with service delivery. Participants are given provider lists during the initial meeting and on an on-going basis as the need arises. Participants are free to choose providers and/or change providers any time, however, modifications or changes must be approved by LAH.

(b)One tool used for monitoring is the Participant Assessment & Caregiver Assessment forms that is completed by the non-agency or agency nurse after each visit to the participant. The RN or agency must submit a copy of the forms to the case manager after each visit. This provides up-to-date clinical and functional information that the CM can use to monitor the effectiveness of the POS, particularly with regard to the participant's health and safety.

(c)Case managers maintain monthly contact with participants to ensure the provision of services including waiver and non-waiver services and to determine if needs are met. Case managers make face-to-face contact with participants no less than quarterly. Documentation is required that visits and contacts were done and that there were no identified problems regarding the provision of services. In addition, case managers are required to be available at the participant's request. Attendant care providers are required to submit PSR forms with each timesheet.

(d) LAH staff will do on-site home visits when there is an unresolved serious and immediate threat (within 2 working days)to a participant's health and safety. When home visits are conducted staff review the the plan of services including the back-up plan to evaluate the effectiveness of the plan and to ensure service deliver and/or identify issues. LAH staff review all POS, if unacceptable the case manager is notified(2 to 3 days). If the timeliness poses a threat to the participant then the issue is addressed within 24 hours. If the case manager is not responsive, LAH staff will then discuss the issues with the case manager's supervisor and/or the case management's program manager.

(e) The annual QCRT review includes reviewing plans of services/ back-up plans and coordination of services for sampled participants. This includes waiver and non-waiver services to ensure the health, safety and welfare needs for the LAH participants are met. When problems are identified with waiver and/or non-waiver services, the team request a Corrective Action Plan (CAPA) from the case management agency.
The case management agency has 60 days to respond to the findings report. If the responses are rejected the case management must respond with an acceptable plan within 10 days. Other remedies include withholding payments can be imposed for continued non-compliance through the Division of Waiver Programs Compliance Unit.

(f) LAH staff discuss all problems and concerns regarding plans of services, coordination of services and complaints

on an on-going basis with the LAH Division Chief and if unable to resolve issues within a 2-3 days will report to the Deputy Director for Long Term Care & Waiver Services. All complaints/events that are a immediate & serious threat to a participant are reported to the Deputy immediately. Complaints & reportable events (RE) are tracked in a RE database on an on-going basis and reports are generated as needed and quarterly for the Waiver Council. In addition, LAH tracks information on an on-going basis regarding POS in the LAH tracking system.

(g) All significant issues and problems are discuss with the Director for Long Term Care & Community Supports and with the Waiver Quality Council. The Waiver Quality Council meets quarterly and will make recommendations for remediation and/or make policy changes based on identified patterns & trends from the reports submitted quarterly by the waiver programs. Changes are also made based on new information & current research/studies.

b. Monitoring Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The case management agency is responsible for the administration of transition services to applicants moving from nursing facilities into the community. The contractor does not receive an administrative fee for performing this service; it is a requirement of the case management contract. The contractor does not have plan of service approval authority.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of Plans of Services reviewed that meet all participant needs either through waiver services or another means. Numerator: Number of Plans of services reviewed that meet all participants needs either through waiver services or another resource. Denominator: Number of POS reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Plans of Services reviewed via tracking system

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of Plans of Service (POS) reviewed during annual Quality of Care Review Team (QCRT) survey which meet participants needs (health and safety, personal goals, other needs). Numerator: Number of POS reviewed during the annual QCRT review that meet participant needs, as defined above, through waiver or non-waiver services. Denominator: Number of POS reviewed during the annual QCRT review.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Review consists of interviews with participants, reviews of records in tracking system, review of records at the case management agency.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: one stage cluster sampling with a 95% confidence level and a 10% error rate
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LAH reviews all POS. Numerator: Number of POS reviewed by LAH.
Denominator: Number of participants in LAH Waiver Program.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Case managers implement & make changes to waiver plans of service based on a participant's request for a change in provider, frequency of service delivery or type of service. Numerator: # of plans of service change requests & updates approved Denominator: # of changes to plans of service requested by participant

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of annual POS reviewed by LAH. Numerator: Number of annual POS reviewed by LAH. Denominator: Number of annual participant redeterminations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Tracking System, Case Management Agency

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other**	☐ **Annually**	☐ **Stratified**

Specify: case management agency		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: LAH tracking system	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: case management agency	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of interviewed participants and/or representatives during the annual QCRT survey that are satisfied and are receiving services in accordance with their POS. Numerator: Number of participants who report satisfaction. Denominator: Number of participants and/or representative interviewed during the annual survey.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: one stage cluster 95% confidence level with 10% error rate
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of participants in the program who have signed "Freedom of Choice" forms for community vs institutional setting. Numerator: Number of signed Freedom of Choice forms. Denominator: Number of LAH participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Management Agency, LAH tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: case management agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: LAH tracking system	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of participants who are given information about participant choices in providers initially & at least annually beginning FY 2010. Numerator: Total number of POS where choice is indicated or documented. Denominator: Total number of POS.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
LAH Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: LAH Tracking System	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
LAH reviews/investigates all complaints about issues with plans of services development. The LAH Quality Assurance Specialist and Medical Care Program Supervisor provides one to one education immediately to the case manager. If no resolution, the LAH staff member will discuss the findings with the case manager's supervisor and/or the case management program manager. The POS will be resubmitted after corrections are made. This process usually is done within 2 to 3 days unless the POS is time sensitive in which case it is resolved with 24 hours. Additionally, If a problem is identified during the annual QCRT survey, a Corrective and Preventative Action Plan (CAPA)is requested within 60 days of receipt of the findings report. The CAPA is reviewed and accepted or rejected. If rejected, the case management agency will need to respond within 10 days with an acceptable plan.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

- **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Participants in the LAH waiver are given the opportunity to direct providers of agency and non-agency attendant care services. Program participants act as the employer of record for non-agency attendant care providers with all of the rights and responsibilities of this role. Participants may recruit, hire, evaluate and supervise their non-agency attendant care providers; alternately they may request assistance with these activities. HB218, passed in 2008, clarified that participants may supervise and evaluate their agency model attendants.

In addition, participants who are cognitively capable may opt to self-direct their non-agency attendant care providers, in lieu of using the nurse supervision service, to assist the participant with routine care and self-administration of medication. The Board of Nursing regulation (COMAR 10.07.11.01D) supports this policy.

Participants make general choices about providers of other services in LAH; each participant is provided with a list of service providers for their region of the state. Participants are encouraged to meet with multiple providers when seeking Environmental Accessibility Adaptations and Assistive Technology services where LAH requires multiple quotes. Participants select the provider where when quotes are comparable and cost-effective.

(b) LAH case managers engage applicants and participants about informed decision making regarding provider choice, model of attendant care, and the availability of self-directed attendant care services. The plan of service reflects all services needed for healthy and safe community living, including areas where the participant will be directing care.

(c)The case manager shares information about attendant care service models (agency and non-agency)and a self-delegation materials in a booklet called "Attendant Care and You." This booklet describes the participant's role in managing providers, explains interviewing techniques and differentiates agency and non-agency models of attendant care. These documents assist the participant in making an informed decision regarding the direction of his/her care.

If the participant is interested, the participant and the case manager (if requested) will identify the tasks that will be self-delegated. The participant and the case manager, as requested, will discuss and develop a job description and back-up plan for the attendant(s) as well as discuss and develop a plan for hiring, screening, interviewing, and training attendant(s).
Upon selection of a potential attendant, the participant will direct him/her to the LAH division to complete the provider enrollment process if necessary. If the participant and case manager agree that they are ready to move forward, a Self-Delegation Agreement will be provided to the participant for signature.

The Agreement will state that the participant will be responsible for the direction and oversight of the attendant(s) and that the POS supports the participant's health and safety while receiving LAH waiver services in the community. The Agreement should only be signed when the participant is ready for total self-delegation and will include the time frame for review of the agreement, but minimally, the participant and the case manger will review it on an annual basis at redetermination. The details of the independent delegation agreement will be indicated on the waiver participants POS and attendant care service tasks are to be noted on the Caregiver Service Plan. The Self-Delegation agreement, POS and Caregiver Service Plan can be modified at any time. If the case manager determines that the participant's health is in jeopardy, a meeting will be held with the participant, case manager, nurse consultant and provider to discuss concerns and options. Strategies to address concerns will be developed such as consumer training, education provided by a nurse supervisor, follow-up training by the nurse supervisor, temporary nurse supervision and/or identification of a new attendant care provider.

If the strategies are determined not to meet the participant's health and safety needs, the case manager informs the participant that they will recommend self-delegation be discontinued and notify the Living at Home Waiver Division about their recommendation. Once notified, the LAH Waiver Division will review the information provided by the case manager and, if necessary initiate documents to reduce or discontinue self delegation of attendant care service. The participant may appeal any decision regarding his/her ability to self-delegate.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Waiver participants must be cognitively capable or have an authorized representative willing to assume employer responsibilities in order to use the non-agency or consumer model of attendant care services. Participants who choose this option for attendant care services are responsible for interviewing, hiring and terminating employees. The Office of Health Services contracts with a Fiscal Intermediary that acts as a payroll agent for these individuals. The Fiscal Intermediary is responsible for ensuring each participant/employer obtains an Employer Identification Number from the IRS, obtaining documentation from providers that supports their legal status to work in the Unites States, for making bi-weekly payroll payments to provider, for withholding all mandatory State and federal taxes, obtaining Workers' Compensation policies for participant/employers and processing unemployment insurance claims filed by providers.

Participant employers may choose to waive certain qualifications that are normally required in order to provide attendant care services under the LAH Waiver Program. These criteria include the age requirement of being 18 years or older, the attendants ability to communicate in English (as long as the attendant speaks the primary language of the participant and is able to communicate with the Nurse Supervisor verbally and in writing), holding a certification in CPR and First Aid and completing a criminal background investigation. Participant employers also may waive the Nurse Monitor visit in advance of the attendant working for 30 days. Under a a separate option, participants may elect to self-delegate Nursing Supervision of attendants ongoing.

This latter option requires a more intensive approval process by the LAH Waiver Division. This option differs from the use of the non-agency or consumer model of attendant care because the participant's authorized representative may not delegate nursing functions as a proxy of the participant.

The cognitively capable participant makes this request to their case manager; the nurse consultant and any other members of the individual's team who participate in the approval process. Participants must demonstrate their ability to complete paperwork that is normally required of the Nurse Monitor; they must show the ability to train attendants. After approval, participants may at any time, discontinue performing this function and resume using a provider to function as a Nurse Monitor. In addition, the LAH Waiver may rescind approval if the participants needs change and they are no longer able to function in this capacity as part of a safe and healthy plan for community living.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Non-agency model of attendant care

Case manager
The case manager provides information about attendant care options upon completing their initial Plan of Service and no less than annually during the re-evaluation process. Participants may switch from one model of attendant care to another at any time or choose to use a combination of attendants. Case managers also provide each participant with information about the option to Self-Delegate Nurse Monitoring of their attendants. Participants

receive this information no less than annually from their case manager. Potential liabilities are that the delegated care and services are not being monitored by a licensed professional with clinical skills. The benefits are that the individual is able to make independent decisions about the care and services provided (self-direction) and is responsible for those decisions.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Applicants and participants may designate an "authorized representative" to assist with the initial or annual Medicaid eligibility process, including plan of services development and directing service delivery. In addition, some waiver participants have Guardians of Person, Guardians of Property, Powers of Attorney or surrogates under the Maryland Healthcare Decisions Act of 1993.

Participants are contacted by case managers on a monthly basis and visited in person quarterly; Adult Evaluation and Review Service staff members see the participant no less than annually. Case managers and Adult Evaluation and Review Service workers are required to report any concerns about financial exploitation to the Local Department of Social Services Adult Protective Services unit. Case managers also report any concerns related to this issue to the Department for further investigation.

The role of the legal representative can be challenged when there are concerns about whether or not their actions are in the best interests of the participants. In situations where there is a Guardian of Person or Property whose actions appear to be self motivated, the case manager makes referrals to legal resources and may initiate a request for the court to review the appointment of Guardian. In these situations, the court may select an alternate Guardian of Person or Property or limit the scope of their role.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Attendant Care	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and

integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- (●) **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - [ ] **Governmental entities**
  - [x] **Private entities**

- ( ) **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- ( ) **FMS are covered as the waiver service specified in Appendix C1/C3**

  The waiver service entitled:

- (●) **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal Intermediary (FI) Services Contractor
Fiscal intermediary services are provided to waiver participants using the non-agency or consumer model of attendant care services. The fiscal intermediary acts as the payroll agent on behalf of these participants; in this capacity, the fiscal intermediary is responsible for issuing bi-weekly provider payroll checks, collecting and paying federal and state tax withholding and unemployment insurance, as well as securing and maintaining workers' compensation insurance policies. The fiscal intermediary assists new participant employers in obtaining an Employment Identification Number from the Internal Revenue Service. The fiscal intermediary collects mandatory employee documentation including the social security number, documents to support the I-9 form, and the IRS W-4 form. The fiscal intermediary invoices LAH an administrative fee for their services and is reimbursed for the Medicaid provider wages, taxes and workers' compensation. The contract is monitored by the Agency Budget Specialist in the Living at Home Waiver Division.

Through the DHMH procurement process this vendor won the bid for the FI contract. This contract was a three year contract with two one year options. Additionally, a contract extension was requested and granted. This contract ends December 2009.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The contractor is paid when invoices are submitted to the Living at Home Division staff. For any participant not using the the agency model the contractor receives a per person per month flat rate.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local**

employment-related taxes and insurance

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☐ **Maintains a separate account for each participant's participant-directed budget**

☐ **Tracks and reports participant funds, disbursements and the balance of participant funds**

☐ **Processes and pays invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☐ **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Fiscal Intermediary Contract is monitored by the Agency Budget Specialist in the LAH waiver. The Fiscal Intermediary contract requires the vendor to submit deliverables monthly and quarterly. In addition, staff monitor all claims paid by this contract through a continuous and ongoing internal process. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers inform applicants about opportunities for self-direction including non-agency attendant care and self-delegation of attendants. Once enrolled, participants receive information, at least annually regarding both self-direction opportunities.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Consumer Training	☐
Personal Emergency Response System	☐
Home Delivered Meals	☐
Dietician Nutrition Services	☐
Medical Day Care	☐
Nursing Supervision	☐
Environmental Accessibility Adaptation	☐
Family Training	☐
Attendant Care	☐
Environmental Assessment	☐
Case Management	☑
Assistive Technology	☐
Transition Services	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Case managers provide information about self-delegating opportunities to program participants when they enroll in LAH and again during the redetermination process. Participants receive written materials about self-delegation from their case managers. These documents explain their role and or liability in self-delegating and assists the participant in making a case managers provide information and education an informed decision regarding the direction of his/her care. After providing an opportunity for the participant to review this information, he case manager will revisit self-delegation.

Participants may choose to self-delegate or opt to work toward this goal with their Nurse Monitor provider and case manager's assistance. The participant and their case manager sign an agreement to confirm participation. The agreement states that the participant will be responsible for the direction and oversight of the attendant(s) and that the POS supports the participant's health and safety while receiving LAH waiver services in the community. The agreement should only be signed when the participant is ready for total self-delegation and will include the time frame for review of the agreement, but minimally, the participant and the case manger will review it on annual basis at redetermination.

In addition, the participant plan of service reflects all services provided and when self-delegation is being used. The Self-Delegation agreement, POS and Caregiver Service Plan can be modified at any time. If the participant decides they would like to resume Nurse Monitor services, they may contact their case manager to request a change in their plan of service. If the case manager determines that the participant's health is in jeopardy, they are required to meet with the participant, any advocate or authorized representative, the nurse consultant and provider to discuss concerns and options.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ◉ **No. Arrangements have not been made for independent advocacy.**
- ○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants who discontinue participating in non-agency attendant care or self-delegation of attendant care receive assistance from their case manager to choose agency based services for attendant care and nurse monitoring. These services are implemented so there are no gaps in delivery of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the case manager determines that the participant's health is in jeopardy, they are required to meet with the participant, any advocate or authorized representative, the nurse consultant and provider to discuss concerns and options for meeting the participant's needs. In situations where the needs are unable to be met through participant directed services, the participant receives formal notice from the LAH Waiver and is given appeal rights. Alternate services are implemented and effective when the participant directed services end so there are no gaps in service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**

Year 1	191	
Year 2	212	
Year 3	236	
Year 4 (renewal only)	262	
Year 5 (renewal only)	291	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Cost are not currently compensated

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**

- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Medicaid provides broad Fair Hearing Rights to individuals who are denied choice of HCBS waiver services as an alternative to institutional care, denied providers of their choice, and whose services are denied, suspended, reduced or terminated. Specifically, COMAR 10.01.04 which governs Fair Hearings stipulates that the opportunity for Fair Hearing will be granted to individuals who are aggrieved by any Department or delegate agency policy, action or inaction which adversely affects the receipt, quality or conditions of medical assistance. This includes adverse action in the case of Level of Care determination; HCBS versus institutional care; choice of provider; choice of services based on substantiated need; and the denial, reduction, suspension, or termination of services. Each waiver participant (and/or his/her family or guardian as appropriate) receives a copy of the notice of fair hearing in the initial waiver application upon enrollment.

Process for Giving Notice to Applicants/Participants
If an applicant or enrolled participant is denied waiver eligibility-medical, technical or financial criteria – he/she and any representative that has been identified by the individual are sent a letter that contains the reason for the denial and a Fair Hearing notice. The Medicaid waiver eligibility unit sends all eligibility denial letters. Denial letters are copied to CMA who will maintain this documentation as part of the participant's waiver record. If an individual requires assistance in pursuing a fair hearing, their Case Manager at the CMA will assist. The case manager informs the participant that filing a grievance or making a complaint is not a prerequisite or substitution for requesting a Fair-Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Staff at the Department accept grievances via calls, emails, in-person visits and letters. Participants are instructed by their case manager to report all issues directly to them. Program participants also have access to the phone numbers of LAH staff and may make contact at any time.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The grievance/complaint system ensures the identification of and the appropriate and timely resolution of administrative service and quality of care complaints related to waiver participants. A complaint is defined as any communication, oral or written from a participant, participant's representative, provider, or other interested party to any employee of the Department of Health and Mental Hygiene (DHMH) or the contracted Case Management Agency (CMA) expressing dissatisfaction with any aspect of DHMH, CMA, or providers operations, activities, or behavior, regardless of whether any remedial action is requested. Administrative, service related and quality of care complaints are reviewed. Quality of care complaints include, but are not limited to: concerns about perceived practitioners or provider's qualifications or competence, adverse experiences, poor outcomes, inadequate care or perceived harm, provider negligence with regards to policy and procedures, medical record documentation and confidentiality issues as well as accessibility and/or availability, which impact care.

The process used for resolving grievances/complaints begins with the Quality Assurance Specialist for the Living At Home Waiver (LAHW) at DHMH, CMA representative, provider or other interested party documenting the pertinent information and the nature of the complaint on the Reportable Events form. The Quality Assurance Specialist for the Living At Home Waiver addresses the issue according to the timeframes outlined below. The Quality Assurance Specialist completes the initial investigation and in conjunction with CMA representative, the participant, family and other related parties, performs all necessary follow-up, summarizes the finding, and determines and implements the appropriate corrective action. The Quality Assurance Specialist and the CMA maintain logs on the grievance/complaint actions reported to identify trends and patterns.

The following are timeframes for complaints resolution based on the Department's revised Reportable Event Policy. Telephone referrals must be done within 24 hours of immediate jeopardy situations including but not limited to the following: abuse, neglect, exploitation, medical emergencies that could result in death or serious injury/impairment. A written report must be completed & submitted to the appropriate authorities for all complaints/events specified in the policy as reportable within 7 days of the event. If further follow-up action is necessary, the report information must be completed within 7 days of the receipt of the original reportable event. All complaints/events must be resolved within 45 calendar days.

Participants always have the choice to terminate the use of a particular provider at any time and may also at any time request a Medicaid Fair Hearing in any situation that gives rise to appeal rights.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Incidents are defined as events or situations that pose an immediate and/or serious risk to the physical or mental health, safety, or well being of a waiver participant. It may also involve the misappropriation of a waiver participant's property or a violation of the participant's rights. Incidents that are alleged to have occurred as well as the results of internal investigations are to be reported using the Reportable Events Form.
Incidents may include an allegation of, or actual occurrence of one or more of the following: Abandonment, Abuse: physical, sexual, verbal, or emotional, Accidents or injuries requiring treatment beyond first aid or patterns of accidents or injuries that potentially indicate a problem. Death: anticipated or unanticipated, Emergency Room visit, Exploitation: theft, financial, and destruction of property, Hospitalizations: anticipated or unanticipated, and an in-patient psychiatric admission, Missing Person, Neglect: nutritional, self, medical, or environmental, Treatment Error, Rights Violation, Use of restraints, including physical, chemical, and seclusion.

All entities associated with Home and Community-Based Services Waivers and supports, including The Division of Waiver Programs (DWP), Administering State Agencies(ASA) or the Single Medicaid Agency (SMA), Case Manager(CM), and waiver providers; personal/attendant care agencies, self-employed providers, and environmental accessible adaptations providers are required to report real or alleged Reportable Events. All Reportable Events shall be reported in full on the Reportable Event Form. The Medicaid Agency administers the LAH waiver through the Living at Home Division.

In instances of alleged or actual abuse, neglect, or exploitation, the person reporting the event must immediately notify Adult Protective Service (APS) office within 24 hours and any other agencies as specified in the Reportable Event Policy. For LAH participants, law enforcement and the Department of Health and Mental Hygiene must also be contacted. Participants and their family, friends or neighbors may file a complaint by calling or e-mailing the LAH Waiver Division office or CMA. Persons may also file complaints in person at the LAH Division office.

The CM shall complete and forward Reportable Events to LAH Waiver Division via password protected email or fax within 7 calendar days of knowledge of the event. LAH Division shall log all events into the Reportable Event database and will also do off-site or on-site reviews based on the nature of the incident or occurrence. The review, follow-up, and action plan shall be completed within 45 calendar days. The ability to complete the Reportable Events forms is not limited to the CM. Any interested party may complete the RE form reporting incidents that may jeopardize the health and safety of participants. The Department will investigate each report and follow-up accordingly based on the timelines set out above.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Case Manager currently explains the Reportable Event policy to the participants and providers involved in their care. In addition, there is information available, including the form and the current policy, to participants and providers on the Department's website. It has been brought to the attention of the Living at Home Waiver that more provider training and ongoing education is necessary due to some inconsistencies with the RE submissions. Living At Home Waiver Division and Quality Council continue to work with other stakeholders to improve the RE process including policies & procedures. LAH Waiver Division is planning to amend program regulations to mandate annual provider training. Reportable Event Policy will be part of this training.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The LAH Waiver Division shall log all events into the Reportable Event (RE) database. The review, follow-up, and action plan shall be completed within 45 calendar days. LAH reviews the RE and all supporting documents to determine whether further review is needed. If further review is needed, the LAH shall follow up with the appropriate parties; determine and implement appropriate action involving the participant, waiver provider, such as, requesting a corrective action plan; and summarizing the findings. The summary information is documented on the ASA RE review Form (completed by the SMA for LAH). For an RE that requires review, LAH shall send a RE status letter to the participant, their authorized representative or family member, and/or provider within 7 calendar days of completion of the review. LAH will also send a copy to the Case Manager (CM). If a RE requires an adverse action (e.g., denial or reduction of services), the LAH will ensure that the provider or participant is provided with their right to appeal. LAH will make recommendations to DWP for review, regarding the need for Medicaid sanctions against providers.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

LAH will compile Monthly Summary Reports of all events. LAH will compile and submit to The Division of

Waiver Program (DWP) summary reports based on an agreed format and data elements including recommendations for systemic changes to improve waiver quality on a quarterly basis. LAH and DWP will review the quarterly reports in the Waiver Quality Council meetings to make specific recommendations for program, policy, or procedure changes and determine the need and provide for technical assistance or training.
The Division of Waiver Program (DWP) shall review LAH quarterly reports from each waiver program. The DWP will compile a consolidated report based on LAH reports for the Waiver Quality Council. This report will review statewide RE trends, identify potential barriers, and make recommendations for improvement. The DWP will prepare an annual report containing analysis of the data that will review statewide trends, identify potential barriers, and make recommendations for improvement. DWP will provide this report to CMS, DHMH, the ASAs or SMAs, and other stakeholders.

Upon completion of the review, LAH will also send a copy to the Case Manager (CM). If a RE requires an adverse action (e.g., denial or reduction of services), LAH will ensure that the provider or participant is provided with their right to appeal. LAH will make recommendations to DWP for review, regarding the need for Medicaid sanctions against providers.

The Quality Care Review Team conducts an annual review of a sample of LAH participants which includes clinical record reviws, observations and interviews. During the review, reportable events/incidents are reviewed for each sampled participant to ensure that health, safety and welfare needs have been met and appropriate actions/interventions were implemented. Additionally, the team conducts face to face interviews with participants or their representatives to ensure that the participant is receiving appropriate care and services and is free from abuse, neglect and exploitation. Team members through survey questions evaluate satisfaction with services based on the participant responses. Corrective and Preventative Action Plans are required from providers and LAH when there is a finding of non-compliance with the requirements. Referrals are made to other entities as needed including but not limited to licensing & certification boards, etc.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- (●) **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

  Provider agencies that are enrolled as Living at Home Waiver providers are monitored by the Office of Health Care Quality when they are Residential Services Agencies and Home Health Providers.

  Adult Protective Services would address/investigate reported incidents of abuse including restraint misuse or seclusion issues (abuse).

  Case managers do monthly telephone contacts and quarterly face to face visits to ensure coordination and delivery of appropriate services. Case managers are trained on how detecting with instances of abuse including unauthorized restraint use and inappropriate seclusion methods.

- ( ) **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  The Department of Health and Mental Hygiene, specifically, the Living at Home Waiver Division, is responsible to ensure that participants are receiving appropriate care and services which includes detecting the unauthorized use of restrictive devices. LAH staff approve all participant plans of services. The contracted case management agency is responsible for monthly participant contacts and quarterly home visits. Both entities are responsible for addressing reportable events/incidents which could involve unauthorized use of restrictive interventions. participants, family members, providers are to report unusual incidents, abuse, neglect, etc. The policy and procedure specifies that Adult Protective Services and law enforcement should be notified for certain events/occurrences. The Quality Waiver Council will be responsible for the analysis of aggregate data on reportable events/occurrences across the various waivers including LAH.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. **Provider Administration of Medications.** *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. **Medication Error Reporting.** *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how

monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
PERCENT OF REPORTABLE EVENTS INVOLVING ABUSE, NEGLECT AND/OR EXPLOITATION; Numerator:Total # of reported and investigated Reportable Events involving abuse, neglect and/or exploitation; Denominator: Total# of total incidents reported.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of providers who receive training concerning identifying & and reporting abuse, neglect & exploitation. LAH will provide training sessions regarding abuse, neglect & exploitation for all attendant care & Nurse Monitor providers in FY 2010. Numerator: Number of provider agencies who receive training. Denominator: Number of Provider Agencies currently working with LAH participants.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of participants who receive training on abuse, neglect & exploitation. CM will discuss & provide information about reporting abuse, neglect & exploitation to participants during the initial planning visit and during the annual redetermination process visit. Numerator: Number of participants who receive training during those visits. Denominator: Number of participants in LAH.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Case management contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Case management contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PERCENT OF REPORTABLE EVENT FINDINGS IDENTIFIED DURING THE ANNUAL QUALITY CARE REVIEW INVOLVING ABUSE, NEGLECT AND/OR EXPLOITATION; Numerator:Total# of Reportable Event findings (CAPAs) involving abuse, neglect and/or exploitation; Denominator: Total# of sampled participants reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
REs/Incidents One-stage cluster sampling, 95% confidence interval

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: one-stage cluster sampling with a 10% confidence interval
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Waiver Quality Council meets quarterly with all operating agencies and /SMA reviews RE/incident data including abuse, neglect, and exploitation. Recommendations are made based on data analysis including trends. Policy and or systems changes are implemented based on these recommendations. Evaluation of the changes and outcomes are reviewed during quarterly meetings.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
In instances of alleged or actual abuse, neglect or exploitation, the person must report or initiate a referral immediately to Adult Protective Services (within 24 hours of the event). For LAH participants, the law enforcement and DHMH must also be contacted. Reportable events(RE) involving abuse, neglect and misappropriation of property/funds are sent to LAH from case managers and providers on a continuous basis. Participants and family members report such incidences to case managers. Case managers investigate all incidents to completion. The LAH Quality Assurance Specialist reviews all of the incidences listed above. On-site visits may be conducted by LAH staff or the Quality Care Review Team. All reportable event information is entered into a database to analyze and compile RE information and generate specific reports to track and trend. LAH staff determine if findings require a corrective action plan or referral to Office of Health Care Quality, Licensing Boards, other agencies,etc. This information is shared on a quarterly basis with the Waiver Quality Council.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**

☐ **Other**
Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
In instances of alleged or actual abuse, neglect, or exploitation, the person reporting the event must make a telephone referral immediately to Adult Protective Service (APS) office (within 24 hours of the event). For LAH participants, law enforcement and the DHMH must also be contacted. Issues involving threats to participant health and safety, including abuse, and neglect will be immediately researched by LAH program staff(Participant Specialist & Quality Assurance Specialist). They must notify the Division Chief and the Deputy Director of Long Term Care and waiver services of the incident within 24 hours.

The CM/SC shall complete and forward the Reportable Events to the ASA via email or fax within 7 calendar days of knowledge of the event.

The LAH staff shall log all events into the Reportable Event database. The review, follow-up, and action plan shall be completed within 45 calendar days.
The waiver's reportable events quarterly reports are reviewed in the Quality Waiver Council to make specific recommendations for program, policy, procedure, and system changes. In addition, the Council will determine the need for technical assistance, training or other remedies/actions. Technical assistance and training will be provided by the appropriate DHMH staff.

The Division of Waiver Program (DWP) shall review quarterly reports from each waiver program. The DWP will compile a consolidated report based on ASA reports for the Waiver Quality Council. This report will review statewide RE trends, identify potential barriers, and make recommendations for improvement. The DWP will prepare an annual report containing analysis of the data that will review statewide trends, identify potential barriers, and make recommendations for improvement. DWP will provide this report to CMS, DHMH, the ASAs, and other stakeholders. Please note the RE policy will be updated to reflect refinements in timelines, categories of events, reporting criteria/requirements & responsibilities within the next four months. In addition, when the policy was written in 2005, LAH was still operating as an ASA in another agency of the State. This will be addressed when the new policy is implemented. During monthly and quarterly contacts case managers furnish participants information concerning abuse, neglect, and exploitation. Participants are encouraged to contact their case manager, DHMH, or their local law enforcement agency to report or seek protection from any abuse, neglect and exploitation. Participants are also given documents with phone numbers and e-mail addresses of offices that should be contacted in the event that are victims of abuse, neglect and/or exploitation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory

requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The analysis of discovery data and remediation information is conducted on an on-going basis due to the waiver design feature of varied types of regular reporting and communications among waiver partners and stakeholders, as well as the forums of the LAH Waiver Advisory Committee and the Waiver Quality Council. LAH is the lead entity responsible for tracking, trending, prioritizing and determining the need for system improvements. These processes are supported by the integral role of other waiver partners in providing data, analyzing data, trending and formulating recommendations for system improvements. These partners include the case managers, providers, participants, LAH Waiver Advisory Committee members and Waiver Quality Council members.

When data analysis reveals the need for system change, ideas for system change are developed by LAH staff.

Implementation plans developed as a result of this process will be shared with stakeholders primarily through the forum of the LAH Waiver Advisory Committee. Input and recommendations regarding changes to the waiver design are invited from stakeholders.

Depending on the nature of design changes, data analysis and plans will also be presented to the Waiver Quality Council for review and recommendations. There may be circumstances when system improvement plans originate in the Waiver Quality Council because there are over-arching design changes indicated that impact all or some of Maryland's HCBS waivers.Annual Completion of the Quality Care Review Team Survey. The Office of Health Services Quality of Care Review Team will conduct an annual review of a sample of LAH participants and require corrective and preventative action plans (CAPAs) for deficiencies. LAH and/or contractors will respond to the QCR Team findings by completing CAPAs and updating the Quality Plan.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The LAH utilizes multiple methods to monitor and analyze the effectiveness of system design changes. Monitoring the effectiveness of the system design changes is an ongoing process performed. Stakeholders also provide a valuable role in providing feedback and in analyzing the results of system change. The primary stakeholder group is the LAH Waiver Advisory Committee which meets three to four times a year. Stakeholders provide valuable input that facilitates assessment of the effectiveness of system changes. Additionally, each waiver presents system design changes and evaluation information to the Waiver Quality Council. Feedback is received from council members regarding the design changes and the results of the evaluation of effectiveness. Council members also share their experiences in monitoring and analyzing system design changes in Maryland's other waivers. The Waiver Quality Council, which meets quarterly, will provide ongoing feedback as monitoring reveals issues that should be brought before the Council. The Waiver Quality Council aggregates, tracks and trends quarterly Reportable Event data from the various waivers. This could result in overarching design changes involving all or some of Maryland's waivers. The Council would monitor and evaluate these changes through data presented to the Council by members representing individual waivers.

Analysis of Reportable Event data, case manager monitoring and provider monitoring are used on an ongoing basis to evaluate the effectiveness of system design changes in addition to the methods previously covered.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The effectiveness of the Quality Improvement Strategy will be evaluated on a bi-annual basis utilizing data resulting from various system design changes. The evaluation will involve the LAH waiver Deputy Director of Long-Term Care and Waiver Services, the LAH Division Chief, Program Manager, the Quality Manager. Results of Quality Improvement evaluations will be compiled in the annual report for the program beginning in March 2010.
The report will also be shared with the Waiver Quality Council and the LAH Advisory Committee for input and feedback.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a)There are no requirements for the independent audit of providers.
(b)(c)There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid Home and Community-Based Services Waiver Programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office. The present contractor is Abrams, Foster, Nole and Williams.

The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid is audited on a two-year cycle.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Office of Health Services will issue correspondence to enrolled LAH providers regarding roles & methodology no less than annually.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Rate methodology is defined in COMAR at 10.09.55.29 C(4)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: N/A

Performance Measure:
State Medicaid Agency will ensure claims paid reflect current rate methodology. Numerator: The number of paid claims within rate methodology. Denominator: Number of paid claims reviewed.

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Fiscal intermediary services are provided to waiver participants using the non-agency or consumer model of attendant care services. The fiscal intermediary acts as the payroll agent on behalf of these participants; in this capacity, the fiscal intermediary is responsible for issuing bi-weekly provider payroll checks, collecting and paying federal and state tax withholding and unemployment insurance, as well as securing and maintaining workers' compensation insurance policies. The fiscal intermediary assists new participant employers in obtaining an Employment Identification Number from the Internal Revenue Service. The fiscal intermediary collects mandatory employee documentation including the social security number, documents to support the I-9 form, and the IRS W-4 form. The fiscal intermediary invoices LAH an administrative fee for their services and is reimbursed for the Medicaid provider wages, taxes and workers' compensation. The contract is monitored by the Agency Budget Specialist in the Living at Home Waiver Division. The Fiscal Intermediary Contract is monitored by the Agency Budget Specialist in the LAH waiver. The Fiscal Intermediary contract requires the vendor to submit deliverables monthly and quarterly to the LAH program. Provider claims are submitted to LAH for payment. The claims are entered into electronic billing system by Medical Care Program Specialist MCPS)staff. All claims are matched against the approved plan of service. The Agency Budget Specialist supervises the MCPSs and checks the entered claims each day. The claims are then submitted electronically to MMIS for payment. After the claims are paid an adjudicated report is generated from MMIS and given to the Agency Budget Specialist who reviews and makes the necessary corrections on unpaid claims.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

In addition, staff monitor all claims paid by this contract through a continuous and ongoing internal process. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

LAH provider rates will be established by the State Medicaid Program (Program) one month before the beginning of the State's new fiscal year and is applicable for the State's entire fiscal year (July through June). LAH communicates rate changes by the issuance of Program Transmittals issued to all participating providers. Program Transmittals are posted on the DHMH website for public review. Rate increases are determined based on established regulations. Program rates automatically increase on July 1 of each year beginning July 1, 2009, by the lesser of: 2.5 percent; or the change from march to march in the medical care component of the Consumer Price index for all urban consumers (CPI-U) for the Washington-Baltimore area. This amount may be reduced based on budgetary restrictions. Rate methodology is defined in COMAR at 10.09.55.29 C(4)

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver claims are paid by one of three methods. 1. For non-Agency attendant care services, the provider sends claims to the contracted fiscal intermediary who acts as the participant employer's payroll agent. This third party entity sends bi-weekly payroll payments to the providers after withholding appropriate taxes. The fiscal intermediary pays claims based on authorization information provided by LAH via the tracking system and invoices the program for reimbursement. The fiscal intermediary sends batches of claims to the Living at Home Waiver program; claims are adjudicated and sent through the Medicaid Management Information System.
2. Claims for all waiver services, with the exception of non-agency attendant care services, Medical Day Care Services, and case management are processed in the Living at Home Waiver Division.

3. Claims for Medical Day Care Program services provided via the Living at Home Waiver Program flow directly from the provider to the State's payment system. The Living at Home Waiver program plans to use the participant Medical Day Care Program authorization form as a means to audit service delivery and recover applicable funds. Claims for case management are sent electronically and monitored by LAH staff after payment. If necessary, funds are recovered electronically.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Living at Home Waiver Program fiscal unit is responsible for entering information from service plans into a database, reviewing claims, and entering claims into the electronic billing system. After the claims are given a final review, they are transmitted into the Medicaid Management Information System in order for payments to be rendered to providers and the federal financial participation to be paid.
Upon enrollment into the Living at Home Waiver Program, participant file, including the approved plan of service, is forwarded to the fiscal unit. The fiscal clerks enter demographic information, the Medicaid number, the date of entry into the program, and the dates for which individual providers are authorized to be paid for waiver services. Claims for services rendered by other providers or for dates not included in the authorized plan of service cannot be paid. In the event that a participant has chosen to modify their plan of service, the case manager submits an updated plan of service inclusive of any changes. When this information is submitted to the Living at Home Program, it is forwarded to the fiscal unit and the plan of service information is updated.
The Living at Home Waiver Program fiscal unit receives DHMH 248 claims forms and provider service records for

attendant care providers. In order for payment to be rendered to the provider, the participant must sign or initial for each date of service and also sign the bottom of the form to verify that services were completed. In addition, the contracted case management agency is required to follow up with participants, during monthly contacts and quarterly face-to-face visits, about any service interruptions.
For transition service claims, the provider must submit a receipt for the items purchased in addition to the invoice and DHMH 248.
In addition, the LAH provider audits include a review of all documentation that has been received. The Medicaid Management Information System provides additional safeguards by rejecting claims for providers whose enrollment is suspended or terminated and for participants whose program eligibility has ended.

When individuals are disenrolled from the program, LAH staff notifies the fiscal unit of the end date for program services.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A fiscal intermediary service is used for payments to providers of non-agency attendant care providers. The fiscal intermediary compares timesheets to authorized units before rendering payment. The current contractor of Fiscal Intermediary services is Public Partnerships, LLC in Boston, MA. The internal fiscal unit at LAH provides oversight for the activities conducted by the Fiscal Intermediary. This includes reviewing monthly invoices, comparing billing forms with units approved in plans of service and verifying authorization. The LAH fiscal unit is responsible for entering claims into MMIS for FFP.

All providers receive billing instructions after their LAH Waiver provider number is issued to them.

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of

5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	41466.81	4908.26	46375.07	45695.56	8968.49	54664.05	8288.98
2	41371.91	5030.97	46402.88	47523.39	9237.55	56760.94	10358.06
3	42238.37	5156.74	47395.11	49424.57	9514.80	58939.37	11544.26
4	42885.32	5285.66	48170.98	51401.82	9800.36	61202.18	13031.20
5	43539.25	5417.80	48957.05	53458.16	10094.50	63552.66	14595.61

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a

who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	**765**	765
Year 2	**850**	850
Year 3	**944**	944
Year 4 (renewal only)	**1047**	1047
Year 5 (renewal only)	**1162**	1162

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was derived from historical program data for Living at Home Waiver participants. Medicaid Management Information System data, electronic billing system data and reportable events inform the waiver about dates in which waiver participants are not eligible for waiver services due to program ineligibility, hospitalization, or re-entry into a nursing facility for 30 or more days. The average length of stay has been calculated on the total days of waiver coverage divided by the average per capita of waiver expenditures as reported on the CMS 372 (S) Lag Report, Reporting Period 7/1/06 – 6/30/07.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

These numbers are derived from historical program data over the previous five years. Data is made available through the Medicaid Management Information System and the Electronic Billing System. Usage trends for individual services were projected by identifying annual percentages of increases or decreases per service across all participants. New waiver services, including Environmental Assessments, Home Delivered Meals, as well as Dietitian and Nutrition Services were projected based on usage data from the Waiver for Older Adults. Case management usage is being based on historical data related to payment of case management as an administrative service. Medical Day Service projections are based on previous use as a State Plan service. Family Service usage increases have been incorporated into these projections in order to allow paid family attendant care providers to receive training required to become a Medication Technician in accordance with Maryland Board of Nursing requirements. Case management services are projected using the best possible estimates based on the current use of this as an administrative service.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

These numbers are derived from historical program data available through the Medicaid Management Information System. These figures have been stable with the exception of a decrease in cost due to implementation of Medicare Part D as noted on the 2007 372 Lag Report. Approximately 45% of LAH participants are dual eligible and decreases have been incorporated into D' projections. Additional deceases

in D' costs are projected based on Adult Medical Day Program being offered as a waiver service that is captured in Factor D.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

These estimates are derived from data obtained through the Medicaid Management Information System about nursing facility users during FY 2008.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

These estimates are derived from data obtained through the Medicaid Management Information System about nursing facility users during FY 2008.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Attendant Care
Case Management
Medical Day Care
Assistive Technology
Consumer Training
Dietician Nutrition Services
Environmental Accessibility Adaptation
Environmental Assessment
Family Training
Home Delivered Meals
Nursing Supervision
Personal Emergency Response System
Transition Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							**25846257.00**
Non-Agency						**8277130.00**	

Attendant Care	☐	one hour	362	1700.00	13.45		
Agency Attendant Care	☐	one hour	565	1810.00	17.18	**17569127.00**	
Case Management Total:							**3536650.25**
Ongoing Case Management	☐	15 minutes	679	348.00	13.25	**3130869.00**	
Transitional Case Management	☐	15 minutes	175	175.00	13.25	**405781.25**	
Medical Day Care Total:							**900467.40**
Medical Day Care	☐	four or more hours p	58	210.00	73.93	**900467.40**	
Assistive Technology Total:							**105089.40**
Assistive Technology	☐	one device delivered	130	1.00	808.38	**105089.40**	
Consumer Training Total:							**162.72**
Consumer Training	☐	one hour	2	2.00	40.68	**162.72**	
Dietician Nutrition Services Total:							**25092.00**
Dietician Nutrition Services	☐	one hour	50	8.00	62.73	**25092.00**	
Environmental Accessibility Adaptation Total:							**225435.00**
Environmental Accessibility Adaptation	☐	one completed modif	113	1.00	1995.00	**225435.00**	
Environmental Assessment Total:							**45105.08**
Agency	☐	one completed assess	113	1.00	399.16	**45105.08**	
Family Training Total:							**19457.28**
Non-agency	☐	one hour	16	16.00	26.93	**6894.08**	
Agency	☐	one hour	20	16.00	39.26	**12563.20**	
Home Delivered Meals Total:							**182400.00**
Home Delivered Meals	☐	one meal	50	640.00	5.70	**182400.00**	
Nursing Supervision Total:							**419590.10**
Non-agency	☐	one hour	82	10.00	26.93	**22082.60**	
Agency	☐	one hour	675	15.00	39.26	**397507.50**	
Personal Emergency Response System Total:							**277002.00**
Maintenance	☐	one service/repair ca	50	1.00	45.00	**2250.00**	
Installation	☐	one device delivered	78	1.00	54.00	**4212.00**	
Monitoring	☐	monitoring for 1-31 (	501	12.00	45.00	**270540.00**	
Transition Services Total:							**139400.00**
Transition Services	☐	one purchase	82	1.00	1700.00	**139400.00**	

GRAND TOTAL:	**31722108.23**
Total: Services included in capitation:	
Total: Services not included in capitation:	31722108.23
Total Estimated Unduplicated Participants:	**765**
Factor D (Divide total by number of participants):	**41466.81**
Services included in capitation:	
Services not included in capitation:	41466.81
Average Length of Stay on the Waiver:	330

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							**28268250.00**
Non-Agency Attendant Care	☐	one hour	402	1700.00	13.65	**9328410.00**	
Agency Attendant Care	☐	one hour	600	1810.00	17.44	**18939840.00**	
Case Management Total:							**4087939.20**
Ongoing Case Management	☐	15 minutes	757	348.00	13.45	**3543214.20**	
Transitional Case Management	☐	15 minutes	225	180.00	13.45	**544725.00**	
Medical Day Care Total:							**1103088.00**
Medical Day Care	☐	four or more hours p	70	210.00	75.04	**1103088.00**	
Assistive Technology Total:							**117160.00**
Assistive Technology	☐	one device delivered	145	1.00	808.00	**117160.00**	
Consumer Training Total:							**247.74**
Consumer Training	☐	one hour	3	2.00	41.29	**247.74**	
Dietician Nutrition Services Total:							**38202.00**
Dietician Nutrition Services	☐	one hour	75	8.00	63.67	**38202.00**	
Environmental Accessibility Adaptation Total:							**251370.00**
Environmental Accessibility Adaptation	☐	one completed modil	126	1.00	1995.00	**251370.00**	
Environmental Assessment Total:							**51047.64**

Agency	☐	one completed assess	126	1.00	405.14	**51047.64**	
Family Training Total:							**20623.04**
Non-agency	☐	one hour	18	16.00	27.33	**7871.04**	
Agency	☐	one hour	20	16.00	39.85	**12752.00**	
Home Delivered Meals Total:							**277920.00**
Home Delivered Meals	☐	one meal	75	640.00	5.79	**277920.00**	
Nursing Supervision Total:							**487186.29**
Non-agency	☐	one hour	93	16.00	27.33	**40667.04**	
Agency	☐	one hour	747	15.00	39.85	**446519.25**	
Personal Emergency Response System Total:							**308388.00**
Maintenance	☐	one service/repair ca	55	1.00	45.00	**2475.00**	
Installation	☐	one device delivered	87	1.00	59.00	**5133.00**	
Monitoring	☐	monitoring for 1-31	557	12.00	45.00	**300780.00**	
Transition Services Total:							**154700.00**
Transition Services	☐	one purchase	91	1.00	1700.00	**154700.00**	

GRAND TOTAL:		**35166121.91**
Total: Services included in capitation:		
Total: Services not included in capitation:		35166121.91
Total Estimated Unduplicated Participants:		**850**
Factor D (Divide total by number of participants):		**41371.91**
Services included in capitation:		
Services not included in capitation:		41371.91
Average Length of Stay on the Waiver:	330	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							**31877331.00**
Non-Agency Attendant Care	☐	one hour	446	1700.00	13.86	**10508652.00**	
Agency							

Attendant Care	☐	one hour	667	1810.00	17.70	**21368679.00**	
Case Management Total:							**4665843.00**
Ongoing Case Management	☐	15 minutes	840	348.00	13.65	**3990168.00**	
Transitional Case Management	☐	15 minutes	275	180.00	13.65	**675675.00**	
Medical Day Care Total:							**1343462.40**
Medical Day Care	☐	four or more hours/d	84	210.00	76.16	**1343462.40**	
Assistive Technology Total:							**130342.38**
Assistive Technology	☐	one device delivered	161	1.00	809.58	**130342.38**	
Consumer Training Total:							**419.10**
Consumer Training	☐	one hour	5	2.00	41.91	**419.10**	
Dietician Nutrition Services Total:							**51704.00**
Dietician Nutrition Services	☐	one hour	100	8.00	64.63	**51704.00**	
Environmental Accessibility Adaptation Total:							**279300.00**
Environmental Accessibility Adaptation	☐	one completed modi	140	1.00	1995.00	**279300.00**	
Environmental Assessment Total:							**57569.40**
Agency	☐	one completed asses	140	1.00	411.21	**57569.40**	
Family Training Total:							**23115.20**
Non-agency	☐	one hour	20	16.00	27.74	**8876.80**	
Agency	☐	one hour	22	16.00	40.45	**14238.40**	
Home Delivered Meals Total:							**375680.00**
Home Delivered Meals	☐	one meal	100	640.00	5.87	**375680.00**	
Nursing Supervision Total:							**553284.34**
Non-agency	☐	one hour	101	16.00	27.74	**44827.84**	
Agency	☐	one hour	838	15.00	40.45	**508456.50**	
Personal Emergency Response System Total:							**343273.00**
Maintenance	☐	one service/repair ca	60	1.00	45.00	**2700.00**	
Installation	☐	one device delivered	107	1.00	59.00	**6313.00**	
Monitoring	☐	monitoring for 1-31	619	12.00	45.00	**334260.00**	
Transition Services Total:							**171700.00**
Transition Services	☐	one purchase	101	1.00	1700.00	**171700.00**	
				GRAND TOTAL:			**39873023.82**
				Total: Services included in capitation:			

Total: Services not included in capitation:	39873023.82
Total Estimated Unduplicated Participants:	**944**
Factor D (Divide total by number of participants):	**42238.37**
Services included in capitation:	
Services not included in capitation:	42238.37
Average Length of Stay on the Waiver:	330

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							**35854606.40**
Non-Agency Attendant Care	☐	one hour	495	1700.00	14.06	**11831490.00**	
Agency Attendant Care	☐	one hour	739	1810.00	17.96	**24023116.40**	
Case Management Total:							**5239953.60**
Ongoing Case Management	☐	15 minutes	932	348.00	13.85	**4492053.60**	
Transitional Case Management	☐	15 minutes	300	180.00	13.85	**747900.00**	
Medical Day Care Total:							**1526099.40**
Medical Day Care	☐	four or more hours/d	94	210.00	77.31	**1526099.40**	
Assistive Technology Total:							**144140.84**
Assistive Technology	☐	one device delivered	178	1.00	809.78	**144140.84**	
Consumer Training Total:							**680.64**
Consumer Training	☐	one hour	8	2.00	42.54	**680.64**	
Dietician Nutrition Services Total:							**65600.00**
Dietician Nutrition Services	☐	one hour	125	8.00	65.60	**65600.00**	
Environmental Accessibility Adaptation Total:							**309225.00**
Environmental Accessibility Adaptation	☐	one completed modif	155	1.00	1995.00	**309225.00**	
Environmental Assessment Total:							**64693.90**
Agency	☐	one comlpleted asses	155	1.00	417.38	**64693.90**	

Family Training Total:							**26332.32**
Non-agency	☐	one hour	22	16.00	28.16	**9912.32**	
Agency	☐	one hour	25	16.00	41.05	**16420.00**	
Home Delivered Meals Total:							**476800.00**
Home Delivered Meals	☐	one meal	125	640.00	5.96	**476800.00**	
Nursing Supervision Total:							**622494.47**
Non-agency	☐	one hour	112	16.00	28.16	**50462.72**	
Agency	☐	one hour	929	15.00	41.05	**572031.75**	
Personal Emergency Response System Total:							**379903.00**
Maintenance	☐	one service/repair ca	70	1.00	45.00	**3150.00**	
Installation	☐	one device delivered	107	1.00	59.00	**6313.00**	
Monitoring	☐	monitoring for 1-31 (	686	12.00	45.00	**370440.00**	
Transition Services Total:							**190400.00**
Transition Services	☐	one purchase	112	1.00	1700.00	**190400.00**	

GRAND TOTAL:		**44900929.57**
Total: Services included in capitation:		
Total: Services not included in capitation:		44900929.57
Total Estimated Unduplicated Participants:		**1047**
Factor D (Divide total by number of participants):		**42885.32**
Services included in capitation:		
Services not included in capitation:		42885.32
Average Length of Stay on the Waiver:	330	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:							**40384490.00**
Non-Agency Attendant Care	☐	one hour	549	1700.00	14.28	**13327524.00**	
Agency Attendant Care	☐	one hour	820	1810.00	18.23	**27056966.00**	
Case Management							

Total:							**5881747.92**
Ongoing Case Management	☐	15 minutes	1034	348.00	14.06	**5059237.92**	
Transitional Case Management	☐	15 minutes	325	180.00	14.06	**822510.00**	
Medical Day Care Total:							**1730263.50**
Medical Day Care	☐	four or more hours/d	105	210.00	78.47	**1730263.50**	
Assistive Technology Total:							**160443.36**
Assistive Technology	☐	one device delivered	198	1.00	810.32	**160443.36**	
Consumer Training Total:							**863.60**
Consumer Training	☐	one hour	10	2.00	43.18	**863.60**	
Dietician Nutrition Services Total:							**79896.00**
Dietician Nutrition Services	☐	one hour	150	8.00	66.58	**79896.00**	
Environmental Accessibility Adaptation Total:							**343140.00**
Environmental Accessibility Adaptation	☐	one completed modil	172	1.00	1995.00	**343140.00**	
Environmental Assessment Total:							**72866.08**
Agency	☐	one completed assess	172	1.00	423.64	**72866.08**	
Family Training Total:							**30100.16**
Non-agency	☐	one hour	25	16.00	28.58	**11432.00**	
Agency	☐	one hour	28	16.00	41.67	**18668.16**	
Home Delivered Meals Total:							**580800.00**
Home Delivered Meals	☐	one meal	150	640.00	6.05	**580800.00**	
Nursing Supervision Total:							**694326.41**
Non-agency	☐	one hour	172	16.00	28.58	**78652.16**	
Agency	☐	one hour	985	15.00	41.67	**615674.25**	
Personal Emergency Response System Total:							**421168.00**
Maintenance	☐	one service/repair ca	75	1.00	45.00	**3375.00**	
Installation	☐	one device delivered	107	1.00	59.00	**6313.00**	
Monitoring	☐	monitoring for 1-31 (	762	12.00	45.00	**411480.00**	
Transition Services Total:							**212500.00**
Transition Services	☐	one purchase	125	1.00	1700.00	**212500.00**	

GRAND TOTAL:	**50592605.03**
Total: Services included in capitation:	
Total: Services not included in capitation:	50592605.03
Total Estimated Unduplicated Participants:	**1162**

Factor D (Divide total by number of participants):	**43539.25**
Services included in capitation:	
Services not included in capitation:	43539.25
Average Length of Stay on the Waiver:	330